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FIGHTING THE AIDS EPIDEMIC OF TODAY: REVITALIZING THE RYAN WHITE CARE ACT

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

ON

EXAMINING REAUTHORIZATION OF THE RYAN WHITE CARE ACT RELATING TO FIGHTING THE AIDS EPIDEMIC OF TODAY

MARCH 1, 2006

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C O N T E N T S

STATEMENTS

WEDNESDAY, MARCH 1, 2006

ADDITIONAL MATERIAL

FIGHTING THE AIDS EPIDEMIC OF TODAY: REVITALIZING THE RYAN WHITE CARE ACT

WEDNESDAY, MARCH 1, 2006

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 3:04 p.m., in room SD–430, Dirksen Senate Office Building, Hon. Michael D. Enzi (chairman of the committee), presiding.

Present: Senators Enzi, Burr, DeWine, Hatch, Sessions, Kennedy, Murray, and Clinton.

OPENING STATEMENT OF SENATOR ENZI

The CHAIRMAN. I call to order this hearing on "Fighting the AIDS Epidemic of Today: Revitalizing the Ryan White CARE Act."

I want to welcome everyone to this hearing of the Committee on Health, Education, Labor, and Pensions. I definitely want to thank Senator Kennedy for his tremendous effort and cooperation in helping to come up with a solution that will make a difference to everyone and will allow us to fight this problem on today's terms, not yesterday's terms. There has been a real spirit of cooperation across the aisle. Senator Murray has played a tremendous role in all of this; Senator Burr—a number of people. I should not start enumerating them, because there is a tremendous interest in getting this done, and we have to get it done.

I have mentioned that even rock star Bono, at the recent national prayer breakfast, while he had kind words for the United States and President Bush, emphasized a little bit our efforts to stop the global spread of AIDS. And today, the committee will be exploring a topic that is no less important, which is our fight against AIDS on the domestic front. We need to fight and win the battle here and abroad, so we have to ensure access to quality health care for all of those who have HIV and AIDS.

In 2004, Dr. Frist, our Majority Leader, and I and some others traveled to Africa, where we witnessed firsthand the devastation that AIDS has brought to the families, to the employers, to the communities. In fact, we noticed in one of the countries that the teen generation is missing.

While we have made significant progress throughout the world, there is much more to do to save lives through education and treatment, and domestically, our Federal safety net program, the Ryan White CARE Act, has provided a framework providing higher-quality care for every American with HIV.

Ryan White, for whom the law was named, was a remarkable young man. He developed AIDS as a teenager, and even in the face of such a huge obstacle, he went on to become a spokesperson for all of those who are battling the disease. He never lost hope for his life. Unfortunately, every day was a battle against those who, for lack of understanding and education, hated what they could not understand.

In response, Congress passed the Ryan White CARE Act to protect and support those battling HIV and AIDS so they could die with dignity and live normal lives without fear of discrimination, rejection, or abuse.

If he were alive today, Ryan White would be a witness to the world that has changed a great deal in terms of those affected by HIV and AIDS and the treatment and care. He would celebrate the new, life-saving drugs, which have meant that the safety net program no longer just helps people die with grace and dignity, but it focuses each day on saving lives through treatment.

However, to defeat this disease, we have to focus on the epidemic of today and not yesterday. In doing so, we acknowledge that the face of HIV and AIDS has changed, and all those living with HIV deserve quality care and equitable treatment. I think that is demonstrated by the work across the aisle, and we are also working across the building with the House folks already to be able to get this done expeditiously.

Of course, one of the problems with any bill at this time of the year is how much time there is to debate something, so we have to be careful that any bill that we construct, we have people in cooperation to keep nonrelative amendments off of the bill, or we never have time to debate it. That is always a difficulty that we have.

But through this hearing and the bipartisan work on it, I am sure that we will arrive at that.

Now, until the ultimate cure, we do have to ensure that those infected with HIV receive our support and compassion. For instance, a mother in Wyoming recently shared with us the story of her HIV-infected daughter, who has benefited from the Ryan White CARE Act. Through the Wyoming AIDS Project, her teenage daughter was able to connect with others who have HIV and learn how to live with the disease. While she is currently enjoying her life as a normal college student, her mother continues to worry about how she will continue to receive her care once she leaves the university and seeks the normal life of having her own business, marrying, having children, buying a house.

Her story is just one of many. Taken together, they do outline the struggle, and they help us see the impact that AIDS has had on too many lives.

Here in the United States, this disease affects more women, more minorities, and more people in rural areas than ever before. According to the Kaiser Family Foundation, more African-Americans are affected and dying from HIV than any other ethnic or racial group in the United States. They represent half of all AIDS diagnoses in 2004, compared to only 25 percent in 1986.

In addition, early in the epidemic, HIV infection and AIDS were diagnosed in relatively few women. Today, according to the Centers

for Disease Control and Prevention, the HIV/AIDS epidemic represents a growing and persistent health threat to women in the United States, especially young and minority women. African-American women account for two-thirds of the new AIDS cases among women.

Finally, the epidemic is moving South. Seven of the States with the 10 highest AIDS case rates are located in the South. Our response must acknowledge these demographic shifts so that we can ensure equitable treatment for all Americans living with HIV.

Our Federal resources for HIV, including those we provide through the Ryan White CARE Act, should go to where the epidemic is today and will be tomorrow—not necessarily where it was a decade ago. If we are to ensure equity, however, we have to first understand the current inequities within the system.

Thankfully, in its June 2005 report, the GAO did highlight the funding inequities related to disparities in funding per AIDS case, the disproportionate effect of "hold harmless" provisions, and the inappropriate grandfathering of funded entities. Just yesterday, the GAO issued a new report that also noted that the Ryan White formulas currently allow for the counting of deceased cases of AIDS to determine the overall funding distribution.

I want to commend GAO for its continued work to highlight these issues and to provide the important information on which we can base our legislative decisions.

With us today is Dr. Elizabeth Duke, administrator of the Health Resources and Services Administration, to testify about the President's principles for the reauthorization of Ryan White. In addition, Dr. Duke, I hope you will further discuss the additional legislative and funding proposals which the President mentioned in his State of the Union Address and submitted in his fiscal year 2007 budget proposal.

I commend you and your colleagues for discussing the tough issues related to those inequities and putting forward a legislative framework for dealing with those issues. Your work will help us focus our Ryan White efforts on saving lives through treatment.

With respect to the committee's work to reauthorize this important program, I want to thank the many diverse organizations that have already provided their insights into critical issues facing the Ryan White CARE Act. We have met with over 50 different AIDS and minority organizations in the past few months, and we will continue to meet and discuss these critical issues. I look forward to that continued dialogue.

People living with HIV/AIDS deserve quality care. At the end of 2003, the Centers for Disease Control and Prevention estimates that there are over 1 million Americans living with HIV/AIDS. Of those, one-quarter of them, which would be around 250,000, are unaware of their HIV infection. In addition, each year, another 40,000 Americans become infected with HIV.

Working together with my colleagues on this committee, we will act on our compassion for people living with HIV by strengthening our domestic response to this crisis by reauthorizing the Ryan White CARE Act this year. Ryan White and the legislation he inspired should become a symbol of hope and compassion for all Americans living with HIV and AIDS.

Senator Kennedy.

OPENING STATEMENT OF SENATOR KENNEDY

Senator KENNEDY. Thank you very much, Chairman Enzi, and I want to thank you for all of your good assistance and help in bringing us to where we are today, and that is the strong commitment that we are going to get good legislation that will be bipartisan and bicameral. We are working with the Administration on this issue. It is the way to work.

We were faced some 16 years ago with the real danger of having ideology override good science and a sense of humanity and decency, and in one of the important successes of the Senate at that particular time, members of both political parties put aside the ideology and really based the underlying legislation on sound science, and what a difference it has made. We are following in that tradition with bicameral legislation, working with the Administration. So I want to thank you very much for all of your good work and your cooperation and help and leadership, most importantly.

Just briefly, Mr. Chairman, today is about one of the greatest public health investments that we have made in this country—the care and treatment of individuals with HIV and AIDS. As I mentioned, 16 years ago, the members of this committee demonstrated their commitment to the care and treatment of Americans living with AIDS by passing the Ryan White Act. Ryan White was a young boy, a hemophiliac, who acquired AIDS through a blood transfusion, was diagnosed when he was 13 years old and passed when he was 16 years old. But he was an extraordinary young person who was an inspiration to all of us, as was his family.

This legislation has been a model of bipartisan cooperation and Federal leadership, and I am proud that this reauthorization process is continuing in that commitment.

Sixteen years ago, Americans were struggling with the devastating effects of the virus, and by 1995, more than 1 million citizens were infected with the AIDS virus, and AIDS itself had become the leading killer of young Americans age 25 to 44. AIDS was killing brothers, sisters, children, parents, friends, loved ones, all in the prime of life.

Since that time, community-based care has become more available; drug treatments have nearly doubled the life expectancy of HIV-positive individuals; public campaigns have increased awareness of the disease. And, while we still seek a cure for AIDS, the Ryan White funds have allowed us to help those infected by the virus to lead long and productive lives through the miracles of good care, treatment, and the availability of prescription drugs.

This is evident in my own State of Massachusetts where, by the end of 2004, a little over 26,000 residents had been diagnosed and reported with HIV/AIDS. Of that number, 42 percent have died, but 58 percent are living with HIV/AIDS; that was not the case 10 years ago.

We in America know of the pain and loss that this disease cruelly inflicts. Millions of our fellow citizens, men, women, and children, are infected with HIV/AIDS, and far too many have lost their lives.

As the challenge of HIV/AIDS continues year after year, it has become more difficult for anyone to claim that AIDS is someone else's problem. The epidemic has cost the Nation immeasurable talent and energy in young and promising lives struck down long before their time, and we must do a better job to provide care and treatment and support for those caught in the epidemic's path.

As we approach this reauthorization, we should take a moment to understand the difference Ryan White has made in the lives of people living with HIV/AIDS. Because of life-saving resources, lives have been extended, and many have now been able to benefit from the Ryan White services needed to continue to live with HIV/AIDS.

We cannot underestimate the importance of mental health services, nutritional services, and transitional housing support that make such a difference every day to those struggling with the disease.

It will be important to ensure that in this authorization, we continue to affirm the structure of the CARE Act, which continues to provide a sound and solid backbone for HIV/AIDS care across the Nation. As we increase our efforts to provide better care and treatment and drugs in rural areas that have seen an increase in the AIDS epidemic, we must ensure that more State flexibility does not cause the collapse of existing structures of care under Ryan White. The establishment of these structures has been enormously powerful and important and valuable in terms of making this program a success.

The Ryan White CARE Act is about more than just funds and health care services; it is about caring and the American tradition of reaching out to people who are suffering and in need of help.

I look forward to the Administration's testimony on the impact that the Ryan White CARE Act has made over 16 years and their thoughts on where we need to go in the future.

I want to acknowledge if I could, Mr. Chairman, the chairman of our committee 16 years ago. The Senator from Utah, Senator Hatch, was the chairman of this committee, led by a Republican. We let that happen from time to time around here. He was able to marshal and bring this committee together and also the Senate in, as I mentioned before he came in, one of the really important health achievements of recent times.

So I want the record of our hearing today to acknowledge that leadership.

Senator HATCH. Thank you, Senator. I appreciate that.

The CHAIRMAN. Thank you.

We will now move to our panel. We have one panel today. I will introduce the witness, and following her testimony, we will move to questions.

Our first and only witness today is Dr. Elizabeth Duke. Since 2002, Dr. Duke has been the Administrator of the Health Resources and Services Administration, where she has improved and streamlined many of HRSA's processes and programs.

Dr. Duke will discuss the current initiatives in place to combat HIV and AIDS in America, as well as next steps in fighting today's epidemic more effectively.

We welcome you and will now hear from you. Thank you.

STATEMENT OF ELIZABETH DUKE, ADMINISTRATOR, HEALTH RESOURCES AND SERVICES ADMINISTRATION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Ms. DUKE. Thank you, Mr. Chairman, members of the committee.

I am thankful for this opportunity to have this time with you to talk about the reauthorization of the Ryan White CARE Act. It is a comprehensive approach to the provision of medical care, treatment and support services to individuals living with HIV/AIDS who have no other means to obtain such care.

As you know, it was enacted in 1990, amended and reauthorized in 1996 and in 2000. The authorization of appropriation expired on September 30, 2005.

President Bush in his State of the Union Message stressed the importance of the program and asked the Congress "to reform and reauthorize the Ryan White CARE Act and provide new funding to States so we end the waiting list for AIDS medicines in America."

Since its last reauthorization, we have been able to provide antiretroviral treatment, primary care, and support services to over half a million people annually living in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, and the Territories. In 2004, an estimated 65 percent of the individuals were racial minorities, 33 percent were women, and 87 percent were either uninsured or received public health benefits.

The Ryan White CARE Act programs have provided important benefits to this population. Overall, AIDS mortality is down, and lives have been extended with HIV/AIDS medications purchased through the AIDS Drug Assistance Program, ADAP. Pregnant women have been provided with care that has allowed them to give birth to children free from HIV infection, and thousands have received support services that have allowed them to access and remain in health care.

The structure of the Act allows for local flexibility and responsiveness in meeting diverse needs in different regions. It fosters collaboration among Federal, State and local governments, and public and private entities to create a continuum of care for people living with HIV/AIDS.

Last July, the Administration emphasized five key principles for reauthorization of the Ryan White CARE Act: (1) to serve the neediest first; (2) to focus on life-saving and life-extending services; (3) to increase prevention efforts; (4) to increase accountability, and (5) to increase flexibility.

The President has made fighting the spread of HIV/AIDS a top priority of his Administration, and he will continue to work with the Congress to encourage prevention and the provision of appropriate care and treatment for those suffering from the disease.

The President requested $2.08 billion in 2006, and the Congress provided us with $2.06 billion. The President's 2007 request for the CARE Act activities is $2.16 billion, an increase of $95 million, for several elements of a new domestic AIDS initiative. Further elements of that initiative focus on testing and other areas, and they are requested outside the CARE Act.

The request will support a comprehensive approach to address the health needs of persons living with HIV/AIDS, consistent with

the reauthorization principles. The budget also includes a new authority to increase program flexibility by allowing the Secretary to transfer up to 5 percent of funding provided for each Part of the Ryan White CARE Act to any other Part of the Act.

Of the $95 million requested, $70 million will address the ongoing problem of State waiting lists and provide care and life-saving medicines to those newly-diagnosed as a result of increased testing efforts. The remaining $25 million will be used to expand outreach efforts by providing new HIV community action grants to intermediaries, including faith and community-based organizations, and to provide technical assistance and sub-awards to grassroots organizations.

In order to serve the neediest first, objective indicators must be established to determine the severity of need for funding core medical services. The Secretary of Health and Human Services would develop a Severity of Need for Core Services Index. This index will be based on objective criteria and will focus on core services. It would take into account variables such as HIV incidence and prevalence, levels of poverty, and availability of other resources.

The Administration proposes focusing on life-saving and life-extending services by establishing a core set of medical services and requiring that 75 percent of funds in Title I through IV be spent on these core services, and maintaining a Federal list of core medications.

It is my pleasure to be with you this afternoon, and I am ready to address questions from you.

Thank you very much for allowing me to be here.

[The prepared statement of Ms. Duke follows:]

PREPARED STATEMENT OF ELIZABETH M. DUKE, PH.D.

SUMMARY

The Ryan White CARE Act is a comprehensive approach to the provision of medical care, treatment, and support services to individuals living with HIV/AIDS who have no other means with which to obtain such care. The authorization of appropriations expired on September 30, 2005. President Bush in his 2006 State of the Union Address stressed the importance of this program and asked Congress to, "reform and reauthorize the Ryan White Act and provide new funding to States so we end the waiting lists for AIDS medicines in America."

Since its last reauthorization, we have been able to provide antiretroviral treatment, primary care, and support services to over half a million people annually in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. territories. In 2004, an estimated 65 percent of these individuals were racial minorities, 33 percent were women, and 87 percent were either uninsured or received public health benefits. Overall, AIDS mortality is down and lives have been extended with HIV/AIDS medications purchased through the AIDS Drug Assistance Program (ADAP). Pregnant women have been provided with care that has allowed them to give birth to children free from HIV infection, and thousands have received support services that have allowed them to access and remain in health care.

The structure of the Ryan White CARE Act allows for local flexibility and responsiveness in meeting diverse needs in different regions. It fosters collaboration among Federal, State, and local governments, and public and private entities to create a continuum of care for people living with HIV/AIDS.

The Ryan White CARE Act is organized into distinct program components.

• Title I provides emergency assistance to Eligible Metropolitan Areas (EMAs) that are most severely affected by the HIV/AIDS epidemic.

• Title II of the CARE Act provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. territories to support a wide range of care and support services and grants to States for Emerging Communities.

• Title III, Early Intervention Services (EIS), supports comprehensive primary health care and certain services for individuals who have been diagnosed with HIV.
• Title IV provides community-based, family-centered services to women, children, and youth living with HIV and their families.
• Part F of the CARE Act includes—the Special Projects of National Significance (SPNS), the AIDS Education and Training Centers (AETCs), and the HIV/AIDS Dental Reimbursement Program—to support innovative programs that hold promise for improving health outcomes.

Principles of Reauthorization

Last July, the Administration emphasized five key principles for reauthorization of the Ryan White CARE Act: (1) serve the neediest first; (2) focus on life-saving and life-extending services; (3) increase prevention efforts; (4) increase accountability; and (5) increase flexibility. The President has made fighting the spread of HIV/AIDS a top priority of his Administration, and he will continue to work with Congress to encourage prevention, and the provision of appropriate care and treatment to those suffering from the disease.

Budget Request

Fiscal year 2006—request $2.08 billion; appropriation of $2.06 billion.

Fiscal year 2007—request $2.16 billion, increase of $95 million for several elements of a new Domestic HIV/AIDS initiative (further elements of that initiative, focusing on testing in the areas of greatest need, are requested outside the CARE Act).

The request will support a comprehensive approach to address the health needs of persons living with HIV/AIDS, consistent with the reauthorization principles. The budget also includes a new authority to increase program flexibility by allowing the Secretary to transfer up to 5 percent of funding provided for each Part of the Ryan White CARE Act to any other Part. Of the new $95 million requested, $70 million will address the on-going problem of State waiting lists and provide care and life-saving medications to those newly diagnosed as a result of increased testing efforts. The remaining $25 million will be used to expand outreach efforts by providing new HIV community action grants to intermediaries including faith and community-based organizations, and to provide technical assistance and sub-awards to grass-roots organizations.

Mr. Chairman, members of the committee, I am thankful for the opportunity to meet with you today on behalf of the Department of Health and Human Services (HHS) to discuss the reauthorization of the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act.

Background

The Ryan White CARE Act is a comprehensive approach to the provision of medical care, treatment, and support services to individuals living with HIV/AIDS who have no other means with which to obtain such care. The program is administered through the HIV/AIDS Bureau of the Health Resources and Services Administration (HRSA) within the Department of Health and Human Services (HHS). The Federal Ryan White CARE Act was enacted in 1990; it was amended and reauthorized in 1996 and again in 2000. The authorization of appropriations expired on September 30, 2005. President Bush in his 2006 State of the Union Address stressed the importance of this program and asked Congress to, "reform and reauthorize the Ryan White Act and provide new funding to States so we end the waiting lists for AIDS medicines in America."

Since its last reauthorization, we have been able to provide antiretroviral treatment, primary care, and support services to over half a million people annually in the United States, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. territories. In 2004, an estimated 65 percent of these individuals were racial minorities, 33 percent were women, and 87 percent were either uninsured or received public health benefits. The Ryan White CARE Act programs have provided important benefits to these populations. Overall, AIDS mortality is down and lives have been extended with HIV/AIDS medications purchased through the AIDS Drug Assistance Program (ADAP). Pregnant women have been provided with care that has allowed them to give birth to children free from HIV infection, and thousands have received support services that have allowed them to access and remain in health care.

The structure of the Ryan White CARE Act allows for local flexibility and responsiveness in meeting diverse needs in different regions. It fosters collaboration among Federal, State, and local governments, and public and private entities to create a continuum of care for people living with HIV/AIDS.

The Ryan White CARE Act is organized into distinct program components. Title I provides emergency assistance to Eligible Metropolitan Areas (EMAs) that are most severely affected by the HIV/AIDS epidemic. To be eligible for title I funding, an area must have reported at least 2,000 AIDS cases during the previous 5 years and have a population of at least 500,000.

Title II of the CARE Act provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. territories. Title II grants support a wide range of care and support services. Title II also provides grants to States for Emerging Communities—that is, localities reporting between 500 and 1,999 AIDS cases over the most recent 5 years. Additionally, title II funds the AIDS Drug Assistance Program (ADAP), which provides medications for the treatment of HIV disease.

Title III, Early Intervention Services (EIS), supports comprehensive primary health care and certain services for individuals who have been diagnosed with HIV. Services include education to prevent transmission of HIV and case management to assure continuity of care. Title III grants expand the capacity of organizations providing primary care to indigent HIV-positive individuals. One third of all title III grantees are community health centers.

Title IV provides community-based, family-centered services to women, children, and youth living with HIV and their families. Services include: primary and specialty medical care, psychosocial services, logistical support, outreach and case management.

The Ryan White CARE Act includes Part F—the Special Projects of National Significance (SPNS), the AIDS Education and Training Centers (AETCs), and the HIV/AIDS Dental Reimbursement Program. SPNS grants support innovative programs that hold promise for improving health outcomes. The AETCs provide education and training on a variety of topics for clinicians who treat people living with HIV/AIDS, with a focus on primary HIV care for underserved populations. The Dental Reimbursement Program assists accredited dental schools and postdoctoral programs with uncompensated costs incurred in providing dental treatment to patients with HIV infection. The Community Based Dental Partnership Program funds eligible entities in their efforts to increase access to oral health care and to support oral health service delivery and provider training in community settings.

Principles of Reauthorization

Last July, the Administration emphasized five key principles for reauthorization of the Ryan White CARE Act: (1) serve the neediest first; (2) focus on life-saving and life-extending services; (3) increase prevention efforts; (4) increase accountability; and (5) increase flexibility. The President has made fighting the spread of HIV/AIDS a top priority of his Administration, and he will continue to work with Congress to encourage prevention, and the provision of appropriate care and treatment to those suffering from the disease. The President requested $2.08 billion for fiscal year 2006 and Congress appropriated $2.06 billion for the program. The President's fiscal year 2007 budget request for the CARE Act HIV/AIDS activities is $2.16 billion, an increase of $95 million for several elements of a new Domestic HIV/AIDS initiative (further elements of that initiative, focusing on testing in the areas of greatest need, are requested outside the CARE Act). The request will support a comprehensive approach to address the health needs of persons living with HIV/AIDS, consistent with the reauthorization principles. The budget also includes a new authority to increase program flexibility by allowing the Secretary to transfer up to 5 percent of funding provided for each Part of the Ryan White CARE Act to any other Part. Of the new $95 million requested, $70 million will address the ongoing problem of State waiting lists and provide care and life-saving medications to those newly diagnosed as a result of increased testing efforts. The remaining $25 million will be used to expand outreach efforts by providing new HIV community action grants to intermediaries including faith and community-based organizations, and to provide technical assistance and sub-awards to grassroots organizations.

In order to serve the neediest first, objective indicators must be established to determine the severity of need for funding core medical services. The Secretary of Health and Human Services (HHS) would develop a severity of need for core services index (SNCSI). This index would be based upon objective criteria and be focused on core services. It would take into account variables such as HIV incidence and prevalence, levels of poverty, and availability of other resources.

The Administration proposes focusing on life-saving and life-extending services by: establishing a set of core medical services; requiring that 75 percent of funds for titles I, II, III and IV be spent on these core services; and maintaining a Federal list of core medications for the AIDS Drug Assistance Program (ADAP).

Requiring States to implement routine voluntary HIV testing in public facilities and working with private health care providers to implement testing will increase disease detection and further prevention efforts. With an estimated 250,000 HIV-positive individuals unaware of their HIV-positive status, testing is a key element in the Administration's prevention efforts. States will be encouraged to adopt important prevention strategies upon receipt of their Ryan White allocations.

Grantees are more likely to be held accountable if: States are required to submit HIV data; grantees are required to report on system- and client-level data and progress; the payor-of-last-resort provision is strengthened; States coordinate HIV care and treatment with other federally funded programs to maximize efficiency and effectiveness; double counting of AIDS cases between eligible metropolitan areas (EMAs) and States is eliminated; and the "hold harmless" provisions are deleted.

Today, because of the way AIDS cases are counted, that is by including cases spanning the last 10 years, metropolitan areas with newer epidemics receive disproportionately less than those with more longstanding problems. In order to more accurately reflect the current status of the epidemic, the provisions that entitle cities to be "held harmless" from funding reductions should be eliminated.

Allowing the Secretary of HHS to redistribute unallocated balances based on the severity of need and allowing planning councils to serve as voluntary and advisory bodies to Mayors will increase flexibility in the program. To maximize all CARE Act funding, unspent funds from titles I and II would revert to the Secretary of HHS and the Secretary would extend those funds to ADAP programs or areas with the greatest need.

We can all be proud of the accomplishments of the Ryan White CARE Act and the dedicated people who make it work. The program has reached over 571,000 uninsured or underinsured persons affected by HIV/AIDS annually. Medication was provided to an estimated 138,834 persons living with HIV/AIDS in 2004. The program strives to reach those individuals who are the most in need of its services. Today, people with HIV/AIDS are living longer and healthier lives in part because of this act. In order to make the legislation more responsive in the future, the Administration urges Congress to take into account the above stated principles in the reauthorization of the Ryan White CARE Act.

Thank you for the opportunity to discuss the Administration's principles for the reauthorization of the Ryan White CARE Act. We look forward to working with the committee throughout the reauthorization process.

The CHAIRMAN. Thank you for your testimony and the expertise you bring. I know that we do have questions, and I'll begin by asking you to explain a little bit further how the President's principles will ensure that the Ryan White formulas more appropriately target the growing number of HIV-infected minorities, women, and people in rural areas. How will the President's new domestic initiative further target these underserved populations?

Ms. DUKE. The principles that the President enunciated basically try to address the epidemic as it is today and address the need to make the provision of funding equitable across the country so that we address those in need first.

Part of it is to address core services, those services which everyone needs, and to ensure that the funds in this act go to support those services. And the key to this is identifying the severity of need.

Right now, we do not have an indicator which is objective, which is nationwide, which people can agree upon as a solid foundation for the awarding of funds. Do we have that now? No, we do not. Do we say that we have the answers 100 percent? No, we do not. We say that together, we can bring in the experts, that we can work with the grantees and with the communities to find ways to provide a standard that people will see as just and fair and that will address the needs of the population which is now facing such tremendous challenges with this disease.

The CHAIRMAN. Thank you.

We were pleased when the President announced in his State of the Union speech that we need to do more to address those who are on waiting lists for life-saving drugs, and the President did provide, I think, an additional $70 million to deal with those issues. How are you going to structure that program? Are we going to focus on other cost containment measures such as lowering eligibility requirements or restricting formularies to determine which States need more assistance to buy the medications?

Ms. DUKE. In the process of reorganization, we will be working with the committee and all of its members to try to find ways to allocate funds for drugs for people whose lives are actually maintained and sustained by these drugs.

In the course of the working out of the new $70 million request, we are looking at the unique issue of waiting lists, and also, services for people newly identified as suffering from the disease who will need treatment. So the purpose of the $70 million is to address both the provision of treatments and also these waiting lists.

Now, waiting lists vary from State to State. Some States have no waiting list. Other States have waiting lists of over 300. So one of the issues is how do you get money to waiting lists, which are made up of the folks who need to get drug treatments today.

So on the $70 million, we are in the process of trying to sort through how to propose to use that money so that we can get through to those who need it. If we put the $70 million through the formulas in the current act, we may give funds to States who cannot use them and not be able to get them to cities and States that desperately need them to give money to the waiting lists.

So we will be working with the committee to try to find a way to get those funds to the people who need them.

The CHAIRMAN. Several of the President's principles focus on creating equity within the formulas by eliminating "hold harmless," grandfathering, and double counting. Can you tell us a little about how these current provisions are creating inequities in the formulas?

Ms. DUKE. Recent studies by GAO and others have shown that the availability of funds for people suffering from AIDS on a per-case basis varies from region to region. Part of it is the interaction among the provisions of the different titles of the act and some of the very well-intentioned protections that exist in this act. This act has so much heart in it, and it reflects, I think, very much the spirit that you talked about at the beginning, trying to make sure that we are providing the very best care across this Nation.

But as the act has come into fruition, one of the challenges that we have is that different adjustments that have been made in different places now come into interactions with each other that have some perverse results. So for example, double-counting—it is really not double-counting; it is partial double-counting—but the effect of it is that the arithmetic playing out of a formula really gets fouled up in implementation, so that if you look just at Title II, Title II has an adjustment that was made in 1996, which was a very charitable and good thing to do, which was an 80/20 provision—and I will not go into the details of the provision, but the net effect of it is that if you look at the difference in two States—a State that has a metropolitan area on the list and one that does not—you will

find that there are different levels of funding available. I can provide more on the that for the record if you would like.

The CHAIRMAN. I would appreciate that.

My time has expired.

Senator Kennedy.

Senator KENNEDY. Thank you very much, Dr. Duke, and thank you for, really, a long career of public service.

Ms. DUKE. Thank you.

Senator KENNEDY. You have been a very dedicated employee who has worked in the Department for years, under a number of administrations, and we are very fortunate to have that kind of dedication and commitment, and we thank you.

Ms. DUKE. Thank you very much.

Senator KENNEDY. Now, we have a short period of time here, and if you would, in your testimony, you referred to the importance of "serving the neediest first" and developing a new medical index that would drive funding. Every State and EMA is capable of demonstrating unmet needs, I think, in each area, but they suffer shortfalls in Federal support for medications. I think the Part D Medicare has been complex and difficult, even under Medicaid, with the variations and other support services.

So do you interpret "serving the neediest first" to mean the neediest individuals nationwide, or do you mean the neediest jurisdictions, because they are not necessarily the same?

Ms. DUKE. Ultimately, in the case of health, I think health comes down to individuals. Individuals are the people who contract the disease, who live with the challenges of the disease, and who ultimately die of the disease. So we really want to find a way to use the jurisdictions and to use the available funds that have so much heart behind them to really provide life-saving, life-extending care for individuals. But we recognize that we have to have jurisdictions that share the concern for these individuals to work and implement a very complex law.

Senator KENNEDY. Just continuing, in assessing the jurisdiction need for funding, you also have a reference to taking account of other existing resources. Would you agree that it is shortsighted to consider the resources that States and locals have committed to supplement the CARE Act—for example, through a strong Medicaid program—in assessing the need for Ryan White funds?

Many States, like my own, have made a huge commitment in health care for the poor and the disabled. Do you think it is really fair to use that investment against them in allocating the Ryan White funds?

Ms. DUKE. I think one of the challenges that we will all face in working together is exactly that challenge. One of the things that we believe in trying to work toward a newly-authorized act is that we need to find a way to identify severity of need that takes into account the poverty of an area, the prevalence and incidence of the disease, and also does address other funds available, other sources of funding. But we have linked that to the continuation of commitments made by resources—State, local, and others.

But we believe that we need to fight through this together so that we do not punish the communities that have provided so well for their citizens, nor do we advantage those who have not provided

well. I think that this is one of those Solomonesque situations in which we are all going to have to work together to find that line where we take care of individuals in the very best way possible, and yet we recognize the superb performance of some areas of this country.

Senator KENNEDY. Well, I appreciate it, and we want to work with you, because I think you are going to find in a number of areas, particularly in States where there has been the highest incidence, there has been a strong commitment to try to look after the range of different services, and it seems to me it would be unfair to penalize them if they have demonstrated that kind of strong commitment.

Let me move on to the code-based system, which you are familiar with.

Ms. DUKE. Yes.

Senator KENNEDY. Massachusetts uses a code-based system to identify HIV cases. They have had good feedback from CDC on the validity and reliability of this code-based system. And in the 2000 reauthorization of Ryan White, it was mandated that by 2004, the Secretary would begin to correct accurate and reliable HIV—and in deciding what is accurate and reliable, consideration should be given to the IOM study that was commissioned. And the IOM study clearly states that both name-based and code-based would be acceptable if it was reliable.

So, why is CDC demanding that Massachusetts collect names when it has never been established that their code-based system did not work, and that system, if it is a credible system under the Institute of Medicine, is indicated to be acceptable?

Ms. DUKE. My understanding—and I am not at CDC—but my understanding is that the interpretation of the laws that exist is that CDC must certify that the systems meet the standards of the law and that they have said that they cannot certify code-based or name/code-based systems.

We have about 13 or 14 States that have some situations—and I believe my colleagues at CDC can work with you on that—where they are having problems with compliance with what they view as the intent of the law.

Senator KENNEDY. It seems to me it ought to be an authentic system, but Massachusetts was a very early State, and we also take great pride particularly in the research that was done with mothers and babies at the Boston City Hospital Pediatric Center, which is really one of the great, great national treasures, doing an enormous amount of research with incredible productivity. But we have had great success with the code-based system. We do not have the time, because my time is up, to explain the reasons for it, and I do not want to be supporting that kind of concept if it does not meet the kind of strict requirements on reliability. But my information is that it does, and also that the Institute of Medicine recognized that if you have a creditable code-based system that it meets the other kinds of requirements. So we will have a chance to visit and talk with the Administration and others on this issue.

My time is up, Mr. Chairman. I thank you.

Ms. DUKE. I will take your concern back and get back to you on that.

Senator KENNEDY. Thank you.

The CHAIRMAN. Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Dr. Duke, welcome.

Ms. DUKE. Thank you.

Senator BURR. Thank you so much, and I reiterate what Senator Kennedy said; thank you for your many years of service.

Dr. Duke, if the unobligated funds within the CARE Act are not spent before the end of March, what happens to that money?

Ms. DUKE. Under the law, the unobligated balances ultimately get returned to Treasury.

Senator BURR. Is there any way for us to recapture that money and have it redistributed via ADAP?

Ms. DUKE. I can absolutely tell you that I have spent hours and days pondering that very question and working with our lawyers, and we ended up with the realization that we did not have the authority to do so—furthermore, it is rather complex the way the interaction of various provisions works—but that we did not have the authority now to be able to bring those funds back in and reallocate them. And that is one of the things that we are asking for, is more flexibility in this law so that perhaps we could do that.

Senator BURR. And were we to follow the guidelines set by the President, would we in fact accomplish that? Would you have the flexibility to recapture and redistribute within ADAP, or do you need additional authority from Congress?

Ms. DUKE. We believe that in this reauthorization, we would have to address this question directly.

Senator BURR. I hope you will work with us to try to address that. As one who has an ADAP program that consistently has a waiting list, I would desperately like to see unobligated funds used, and I cannot think of a better way than for them to be used for those HIV and AIDS patients.

Ms. DUKE. As in all provisions of this law, we will be happy to work with this committee to try to see what we can do together.

Senator BURR. Dr. Duke, could you help me to try to understand or explain to me why, when we combine the money that is going to each State under Title I and Title II funding, a State like California would receive $5,200-plus per AIDS case, while North Carolina would receive $3,700, Mississippi, $3,400, and Iowa, $3,300?

Ms. DUKE. This is a complex interaction of the multiple titles and the very well-intentioned adjustments that have been made within those titles.

For example, the interaction between Title I and Title II—some States do not have an Eligible Metropolitan Area, an EMA, and the impact of having an EMA is that funds get allocated to that State based on the supplemental funding in Title I that recognizes need, but they also get funding from a formula that recognizes their share of the AIDS cases.

So if you have an EMA in your State, you get funding under Title I; then, you get Title II funding, and Title II funding comes to the State again in two pots of money. One pot, about 97 percent of the money, comes through a formula, and then there is 3 percent set aside for severity of need.

When those funds get allocated, that 97 percent gets allocated, again, we have issues about how you allocate. If you have an EMA in your State, 80 percent of the funds get allocated across the entire State, including the EMA, which has already been counted in Title I. So then, when you go to Title II, they get counted again in 80 percent of the allocation; but in 20 percent, according to the——

Senator BURR. And that would be the double-counting?

Ms. DUKE. Yes, it's what you call double-counting, yes, sir—partial double-counting.

Senator BURR. OK. I just wanted to make sure that I understood it.

So, we created the CARE Act for what reason?

Ms. DUKE. I think that the opening statements reflected very much the heart of the U.S. Congress in recognizing that we wanted to take care of folks who were facing a horrible disease.

Senator BURR. Haven't we made this way too complicated?

Ms. DUKE. This is an extraordinarily complex statute.

Senator BURR. You just went through a very detailed answer to what I knew was not a simple question, but you did it without notes; you did it because you have spent time in it, and you have been asked the question before. And I am not exactly sure how I can go back and explain to a population, many of whom do not have available funds because we have a significant increase in the population, that the increase in population does not necessarily trigger proportionately what we should get as it relates to this very limited pot of money. And I am desperately trying as we have an opportunity to reauthorize to be able to go home and say, "Once again, we were not perfect, but we got it better," and I have every hope that I can look at Senator Kennedy and say we made it less complicated than to make it more complicated.

But I am fairly confident today that if we cannot get rid of certain things like double-counting, I am not sure that your explanation can ever be less than what it was, which is very difficult to follow, although I have every confidence in the world that you know exactly what you are talking about. If Part D is confusing to seniors, I can imagine what this is to those people who use the money to assist an HIV population in my State.

Ms. DUKE. It is a very complex law, and its complexity comes out of the fact that this is a complex epidemic. But our hope is that all of us working together can produce something that is fair and equitable and understandable.

Senator BURR. I look forward to that.

Mr. Chairman, I would ask unanimous consent that we be allowed to send Dr. Duke some additional questions. I think we will need it in this process.

The CHAIRMAN. Absolutely. You do not even need to ask permission for it. Actually, we will allow any member's written statement to be entered into the record. If a member would like to submit additional questions for the record, we will ask Dr. Duke to answer those additional questions. Given the technical nature of this program, we may not want to ask here—we do not want the audience going to sleep—but it is information that we need that will be helpful for us as we re-examine this program.

The CHAIRMAN. Senator Clinton.

Senator CLINTON. Thank you very much, Mr. Chairman.

Welcome, Dr. Duke. We are delighted to have you here, and thanks also for your years of service.

Ms. DUKE. Thank you so much.

Senator CLINTON. I think we are all committed to ensuring that this program remains strong and viable and able to help as many people living with HIV and AIDS in our country as possible. I hope, too, that we do not try to expand the reach of the CARE Act by removing resources from areas which have historically been hardest hit by the domestic AIDS epidemic.

For example, the need is greater than ever in my State of New York. Although New York only has 7 percent of the Nation's population, it has 17 percent of the Nation's AIDS cases. Over 100,000 people living with HIV and AIDS reside in New York—more than any other State in the Nation. And the epidemic unfortunately shows no signs of abating—more than 7,000 new cases of AIDS were reported in New York in 2004, again, more than any other State in the Nation.

In response to a letter that I sent to you in October, with my colleagues in the New York delegation, outlining our concerns over the President's principles, you stated that "The principles are proposing to target Federal funds to the most heavily impacted communities and to serve the neediest first."

Such a statement would seem to indicate strong administration support for a State like mine, which has borne the brunt of the epidemic. Yet, if the Administration's principles were implemented, as I understand them at this point, New York would experience decreases in funding that would terribly impact our ability to provide care and treatment to the 100,000 people we have living with HIV.

Specifically, the principles would require 75 percent of the funds to be spent on a yet-to-be-defined list of medical services, establish a severity of need index that would take into account State spending, and make changes in the Title II formula that would shift funding away from areas with Title I Eligible Metropolitan Areas.

Could you explain—because it is obviously important to me, to Senator Kennedy, to California, and to other States with large populations—how the President's proposal for reauthorization would help and not hurt heavily-impacted communities with demonstrated need, like New York?

Ms. DUKE. I think that the word "principles" is the key here. We have principles that we put forth, and what we have done is we have laid out some of what we see as problems with the equity of the statute as it exists.

We are very aware of the tremendous job that New York has done and of the tremendous burden that New York bears in this epidemic. The reason we are working with principles rather than with some kind of assertion that we have truth, beauty, justice, and light on our side here, rather, what we are saying is here are some principles and here are some things that we see that are problems in the statute as it now exists.

So what we have tried to do is say, for example, on the 75 percent, of course, when I got your letter, I asked what's going on with this, what are we doing now—and then, of course, I was inundated

with statistics. It basically boiled down to that we are already doing more than 75 percent.

Now, what are core services and so forth? Everybody has a list of core services, and what I wanted to know is is there any commonality. There is a lot of commonality about what core services are.

So what we are trying to find and what we are trying to put forth in these principles is can we, working together, find a way to address the reality that a big State like New York, with a big EMA like New York City, needs recognition and funding to deal with the epidemic as it appears in that jurisdiction, but that at the same time, we need to have some equity for the States that do not have an EMA and where we get this tremendous difference in per-case funding.

And I honestly believe that all of us working together can sort our way through this to get a precise and manageable way of doing it that does not reward bad behavior or punish good behavior. That is what we are seeking here, and we do not pretend to have all the answers, but I believe we can do it together.

Senator CLINTON. Well, I certainly welcome your offer to work with you, because I think that is what all of us are striving for. And I could second Senator Burr's request that we look for a way to recapture funds that are not used. We did work that out in the Children's Health Insurance Program, the S-CHIP program, so maybe that is one of the models we can look at, because we had the situation there where some States were utilizing those funds, and others were returning them to the Treasury, and we were able to transfer those.

Now, when we look at the severity of need index, we have to also take into account the effort that State and local governments have made, which I do not think we want to discourage or disincentivize. I think we also have to take into account the impact on Medicaid—because certainly the bulk of the medical costs in New York are paid for by Medicaid, not by the Ryan White CARE Act—with the cutbacks in Medicaid, how that is going to impact the caseloads that are already on the rolls for HIV/AIDS. And again, I would just raise these as cautionary notes.

I also hope that we could study carefully the support services. I know there are some who think that the medical services and the access to medications are really the end-all and be-all, but we have found in New York, from a lot of trial and error and now some very good programs, that nutrition services, case management services, and emergency housing assistance are really medically-related and necessary services.

So if we take the 75 percent CARE Act funding and direct it to the as-yet-undefined set of core medical services, how will we deal with case management and some of these supplemental services that we at least have found were necessary to keep people alive and to keep them able to go on with their daily lives when they were under tremendous health pressures?

Ms. DUKE. One of the things we did in trying to look at where we are now in terms of where we are going to perhaps go—we tried to look at what are we spending money on now. What we found was that about 29 percent of the money gets spent on health care;

about 42 percent of it gets spent on pharmacy. And we included in that definition case management services.

So when we look at this definition of what is a core service, as you look across the definitions, and you sort of play almost those children games, where you tried to make things line up, one of the things that happens when you line up these various lists is that you find that there are commonalities—the idea of having outpatient services, having x-ray, having access to oral health care, mental health care, behavioral and substance abuse care—when you put all of those in, one thing that you also find is that case management comes up on most of those lists.

Senator CLINTON. Thank you very much, Dr. Duke.

Ms. DUKE. Thank you.

The CHAIRMAN. Thank you.

Senator Sessions.

Senator SESSIONS. Thank you, Mr. Chairman.

Dr. Duke, I want to ask just a question or two that relate to a matter that has come to my attention that concerns me. I know that Alabama's AIDS program is working hard; they have some very fine people involved in it. My daughter served on the board in Mobile, and they raised money and had auctions and things that people do.

Then, I have come to be aware that the larger cities, the larger metropolitan areas, receive more money per patient—substantially more, apparently—than the smaller areas. I do not think Birmingham, for example, is close to three-quarters of a million people, so they do not qualify as a larger area. So we have no area in the State that qualifies.

I recently heard about people who had to leave New Orleans and go to other parts of Louisiana to live, and they had been receiving about $1,200 per month in assistance for drugs for treatment and so forth, and upon leaving New Orleans, their amount changed to $1,200 per year. To me, that seems unconscionable, that a single mother with AIDS in Alabama or in rural Louisiana is going to get substantially less than somebody who lives in New Orleans.

Rural health care is already facing many adverse funding formulas. For example, a doctor in Alabama who does a gall bladder operation is paid a lot less than a doctor in a big urban area, for the very same procedure.

So we have a problem here if those numbers are somewhat correct, and the State people tell me that they are. Dr. Williamson, the State health officer and a fine professional, says it is a real problem for them, that there are 300 on the waiting list right now that they do not have funding to take care of. I think our AIDS problem in Alabama is growing at least on par with other areas of the country and perhaps faster.

So I guess I would ask you if you are aware that there is a funding disparity here, and do you have any plans to fix it.

Ms. DUKE. Yes, sir, we are very aware of the funding disparities as you go across the country. If you look at the funding in a State that has an Eligible Metropolitan Area versus a State that does not, then, the reality of differentials affecting the amount of money available per case becomes quite visible.

One of the things that we hope——

Senator SESSIONS. Of most Eligible Metropolitan Areas, which would have the most capability to support locally, if need be, AIDS patients—the larger areas or the smaller ones? I mean, why would we give more to the larger areas?

Ms. DUKE. One of the things that we have proposed here is trying to work through this dilemma, because we know that the formulas as they now exist produce this result, which was really not an intended result, that someone living in a rural area—the case—would get less funding.

So we believe that working together, we can plow through this really complex law with these different formulas and try to deal with this equity issue, and that is an important piece of it. And the President in his State of the Union talked about trying to reform this act to address some of these issues. And also, in the budget for 2007, the President talked about trying to find a way to address the waiting list issues and has asked for funding that would allow us to get money to States that have waiting lists.

So just to sum up, we are very concerned with these issues, and we believe that, working together——

Senator SESSIONS. How do you propose fixing it? Is there anything in the fiscal year 2007 budget that would fix this?

Ms. DUKE. On the waiting list, yes, sir, the $70 million.

Senator SESSIONS. Well, let's put that aside. I am not sure that that deals with the allocation disparity. What about the allocation disparity? Why don't you look at this and propose a fix?

Ms. DUKE. As I said earlier, that is of grave concern to us, and we do believe that, working together and using the principles that we have laid out, we can together find a way to deal with that problem of allocation, which is an interaction of these various titles as they have developed over the last 16 years. Some of the well-intentioned changes that got made in titles have had some rather challenging implementation issues, and those are the issues that you have brought up, and we hope to work with this committee to see if we cannot find a way through this.

Senator SESSIONS. Well, sometimes inequities occur because of unintended consequences; sometimes because of clever legislators. I do not know how this occurred, but if the numbers are anything like the numbers that I am hearing from my State and what I have heard about Louisiana, wouldn't you agree that that is inequitable?

Ms. DUKE. We have said that we do not have the same standard of funding of cases as we go about the country. We agree that we have equity problems in the law. The question is how can we work through those inequities in a way that together, we can find something that we believe is fair and just for the American people. And I think that is our challenge over the coming months.

Senator SESSIONS. Will you help us?

Ms. DUKE. Absolutely. It is my pleasure to help you all.

Senator SESSIONS. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. I believe that Senator Burr had one quick dollar-specific question.

Senator BURR. Thank you, Mr. Chairman.

Dr. Duke, I am curious—with the emergence of Part D Medicare, we have now provided an avenue for those individuals who had

been classified as disabled from an affliction of AIDS. We have now opened an avenue for them to get their medication.

Do you know, or do we have numbers on what the size of that population may be that this year has access to medications under that program that did not prior to Part D?

Ms. DUKE. I will have to get that for you for the records, sir, but I will.

Senator BURR. Would you be kind enough? I think, Dr. Duke, that what you have heard from everybody is that our goal as we change these programs, as we reauthorize them, as we reshape them, whatever the final determination is, is that the focus needs to go on how we get the medications to those individuals who need it. I have dealt with this for long enough that I know it is impossible to do without ruffled feathers, without winners and losers, and as long as in the loser category, it is not a person with HIV or AIDS, then we have to be bold enough to complete this process. We need to make sure that more have an opportunity to be in the "winner" column regardless of where they are geographically.

I thank you once again.

Dr. Duke. Thank you, sir.

The CHAIRMAN. Dr. Duke, I want to thank you for your testimony and your answers.

I want to thank my colleagues for their attendance and interest, and I know there are people who want to submit some additional questions. We will not have any further questions at this time. This hearing has raised a lot of critical issues highlighting the need to retool our efforts to fight the AIDS epidemic of today, and we will be working on that. Senators will have an opportunity to submit additional questions. The record will remain open for 10 days for those questions to be answered.

I thank everybody for their attendance and participation. The hearing is now adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

RESPONSE TO QUESTIONS OF SENATORS ENZI, KENNEDY, BURR, HATCH, DODD, REED, AND CLINTON BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

QUESTIONS OF SENATOR ENZI

Rural Areas

Question 1. Dr. Duke, one of the Ryan White CARE Act White House principles was the inclusion of a severity of need process in determining the Ryan White funding formula allocations. One of the key debates that we have on the Hill is one regarding the cost of health care in rural versus urban areas. That debate maintains itself in Ryan White because States who have no cases in metropolitan areas receive more than ¼ less funding per case. According to the GAO, States without separate funding for metropolitan areas received $3,592 per estimated living AIDS case, while States with a bulk of cases in metropolitan areas received $4,955 per case. Although I won't recreate the full debate here, I do want your thoughts on how rural States should deal with the increased number of cases in their areas, given their general lack of large health care infrastructure. For instance, in my own State of Wyoming, we only have two infectious disease doctors in the whole State to treat over 200 HIV-infected individuals. In addition, can you help outline specific issues with rural areas scaling up to provide their care?

Answer 1. As small towns and cities experience a rise in the number of HIV/AIDS cases, patients may face obstacles to effective care. In addition, rural residents who have or are at risk for HIV infection may also need support services. Some of the barriers to care in rural areas exist for individuals seeking any type of medical treatment and support services in these areas. Some of the unique issues include having HIV/AIDS; less access to intervention and prevention efforts; fewer resources and information about HIV/AIDS; long distances between homes and medical facilities; shortages of clinicians (doctors, nurses, psychologists, counselors, and social workers) able to diagnose and treat HIV infection and comorbidities; and fewer people with health care coverage. Transportation continues to be a barrier. For patients who have cars or can borrow cars to make frequent trips to distant clinics, the high cost of fuel can be prohibitive. Care in rural areas is particularly challenging for HIV-positive caregivers, such as HIV-infected mothers who find it difficult to care for children and spend full days traveling to and from medical appointments.

Recommendations for improving the quality of life for persons with HIV/AIDS in rural areas include conducting support sessions by telephone, helping patients identify support services in their area, using telecommunications to provide rural patients with information about contemporary treatment regimens, and assisting them in developing and maintaining strong social support networks.

Some examples of how rural States have dealt with increased cases in their areas:

- In Vermont, the University of Vermont provides care throughout the State by providing care in three small cities, in which persons can travel within a 2-hour radius to get to these clinics. The clinics are run by a nurse practitioner with supervision from University Infectious Disease physicians, who travel monthly to the outlying sites. The key to high quality HIV care, particularly prescribing of Highly Active Antiretroviral Therapy, is consultation with experts. The CARE Act funds the University of California—San Francisco Warm line—through which clinicians may consult with HIV care specialists. This service is used most frequently by rural clinicians.
- Because of stigma, it's often effective to have services placed in small cities, i.e., cities with populations of less than 30,000. In Pennsylvania, clinicians from the Hershey Medical Center travel to several areas within a 2- to 3-hour radius to provide medical care. Clinicians can often work in consultation with community physicians who may have limited experience in HIV care. In frontier States, this model is more challenging because the distances are farther. In these States, expert HIV physicians often fly to other cities within the State to provide services.
- In Maryland, Johns Hopkins University provides care in local health departments in several adjacent rural counties. HIV-positive patients without complicated medical needs are served in their own locales by Hopkins' physicians.

Question 2. How is HRSA working with the CDC to help low-incidence States prevent new infections and reduce incidence rates, given the changing HIV epidemic? What specific programs does HRSA have to help low-incidence States serve the needs of newly detected individuals?

Answer 2. The CDC Advancing HIV Prevention Initiative aims to reduce HIV transmission by encouraging people to learn their HIV status; to provide referrals

to care, treatment, and prevention services; and to prioritize prevention services for persons with HIV. All of the CDC initiative's main precepts directly affect HIV care and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau's (HAB) programs: to make HIV testing a routine part of medical care; to prevent new infections by working with persons diagnosed with HIV and their partners; and to further decrease perinatal transmission by screening all pregnant women for HIV. HAB is working closely with the CDC to collaborate on projects that support the initiative, as well as working to promote HIV prevention, counseling, and testing in HRSA programs. Activities that support the CDC's initiative currently include: training providers on HIV counseling and testing, use of the Rapid test and integrating HIV prevention into clinical care through our AIDS Education and Training Centers (AETC) programs; testing models that integrate prevention activities into clinical care settings; collaboration with CDC and CMS to identify methods to streamline and integrate case management services; and ways to promote perinatal counseling and testing activities. In addition, CDC and HAB worked together in an effort to quantify the impact of this initiative on HIV care and treatment programs.

In November 2002, in order to promote better coordination of prevention and care resources, the Health Resources and Services Administration AIDS Advisory Committee (HAAC) and the Centers for Disease Control and Prevention Advisory Committee on HIV and STD Prevention (ACHSP) were combined into one entity.

The resulting body, the CDC/HRSA Advisory Committee on HIV and STD Prevention and Treatment (CHAC), helps CDC, HRSA, and HHS determine how best to identify and respond to the prevention and health care service needs of communities and individuals affected by HIV and AIDS and other STDs. CHAC offers recommendations on strategic, programmatic, and policy issues, and provides general support to the agencies as they respond to emerging HIV or STD-related health needs.

Code-Based Systems

Question 3. Can you clarify something for me? How long has CDC been stating that names-based reporting is an accurate and reliable method for HIV reporting? How many times and in what way has CDC made this information available to the States? What documentation has CDC provided about the issues of having code-based systems? What are the major barriers for those code-based systems, keeping CDC from accepting them as "accurate and reliable?" What data do you have about the cost of code-based systems as they relate to name-based systems?

Answer 3. At the beginning of the HIV epidemic, before the discovery of the etiologic virus, surveillance of this public health problem could only be conducted by tracking AIDS cases. In the early 1980s when all States implemented mandatory reporting for this condition, they used the name of the affected person as the patient identifier. All other reportable diseases in all States are and have been monitored using this method except for diagnosed HIV infections that have not progressed to AIDS.

Currently, seven States and the District of Columbia use a code rather than name as the patient identifier for non-AIDS HIV. In 1985, when the first diagnostic test for HIV became available, Minnesota and Colorado were the first States to begin conducting surveillance for persons diagnosed with non-AIDS HIV. These States used name-based reporting for this condition as well. By the beginning of 1994, when CDC began to support national aggregation of surveillance data on non-AIDS HIV, 25 States collecting this information were using name-based systems. Two other States (Connecticut, and Oregon) were using codes.

Numerous formal evaluations of name-based reporting for AIDS were executed during the late 1980s and early 1990s. The evaluations demonstrated that this was a highly accurate and reliable method for conducting surveillance for AIDS. Because the vast majority of States were using name-based systems for non-AIDS HIV, name-based AIDS surveillance had been shown to be highly accurate and reliable, and no formal evaluations of code-based systems had been conducted, CDC determined that only name-based reports would be accepted into the data collection system for the national database. During 1994, two other States (Maryland and Texas) implemented code-based reporting systems.

In 1995, CDC convened a meeting of States conducting non-AIDS HIV surveillance (code and name-based) to review the operational, technical, and scientific challenges associated with surveillance using coded identifiers. The States recommended that CDC evaluate additional coded identifiers and assist them in documenting and disseminating the results of their findings. With CDC collaboration and support, Texas and Maryland conducted an evaluation of their code-based systems based on reports submitted during 1994–96. This research documented nearly 50 percent incomplete reporting and other deficiencies in the accuracy and reliability of these sys-

tems. Texas subsequently switched to name-based reporting whereas Maryland continued to execute and evaluate their code-based system.

In 1997, the Council of State and Territorial Epidemiologists promulgated a position statement recommending the addition of non-AIDS HIV to the national public health surveillance system. In 1999, CDC published formal guidelines for the conduct of non-AIDS HIV surveillance. These recommendations provided performance standards for evaluating HIV surveillance systems (name or code), reviewed the existing evidence for the reliability and accuracy of varying methods for reporting this condition, and based on the existing evidence at that time, "advised" that States use name-based systems. However, CDC also stated that it would continue to work with States to develop and implement standardized methods for evaluating surveillance systems using name and code-based data. Throughout all subsequent national meetings, as well as discussions with States, CDC reiterated that it "advised" States to use name-based reporting, and the agency commitment to develop standardized evaluation methods.

In 2001, CDC funded 10 States (3 code and 7 name) to pilot methods for evaluating these systems. (Two of these code-based States—Illinois and Washington—that participated in this pilot, have subsequently switched to name-based reporting.) Also, because it was clear that due to the growing availability of Highly Active Anti-Retroviral Therapy, persons with HIV and AIDS were living longer, healthier lives, and were more likely to move across and within States. CDC launched a national evaluation of interstate duplicate reports (i.e., multiple reports from multiple States that provide information about one person). From the outset of this latter evaluation, it was clear that technical problems made it impossible to efficiently include code-based reports. These problems included: (1) the variety of codes used by different States conducting this type of surveillance, (2) the lack of a central, standardized, national database with code-based reports, and (3) the inability of States using codes to adequately communicate with States using names regarding potential duplicate records. Therefore, only name-based reports could be included. The results of this assessment indicated that the number of duplicate reports for non-AIDS HIV cases varied a great deal from state-to-state, and exceeded the proportion of duplicate case reports for AIDS cases.

After the interstate duplication study was completed, and the results were presented at the national meeting of the Council of State and Territorial Epidemiologists, CDC did three things: (1) identified and eliminated all identified records attributable to duplicate reporting from the national database; (2) implemented a formal system for coordinating the ongoing identification and removal of duplicate reports from the national database; (3) in July of 2005 published and disseminated a "Dear Colleague" letter signed by the director of CDC stating that the agency was upgrading the guidance for States to implement name-based HIV reporting from "advising" to "recommending." The letter also indicated that CDC would focus technical assistance on assisting States transitioning from code- to name-based systems to assure that their data could be integrated into the national HIV (non-AIDS and AIDS) data system as quickly as possible. However, the implementation and dissemination of the methods for conducting evaluations of the accuracy and reliability of reporting systems within States, regardless of reporting method, would continue.

CDC's policy is to report HIV infection and AIDS case surveillance data only from areas conducting confidential name-based reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. Personal identifiers are removed before data are provided to CDC. HIV surveillance that is conducted using coded patient identifiers has not been shown to routinely produce equally accurate, timely, or complete data to that conducted using confidential, name-based surveillance methods. Code-based and name-to-code systems are also more expensive to implement than name-based systems. Currently, only confidential, name-based HIV reporting, integrated with AIDS surveillance data, can be used by States to identify and remove cases that are counted in more than one State before they are reported to CDC's national surveillance database.

References

CDC. Guidelines for National Human Immunodeficiency Virus Case Surveillance, Including Monitoring for Human Immunodeficiency Virus Infection and Acquired Immunodeficiency Syndrome. MMWR 1999; 48(RR13);1–28.

CDC. Evaluation of HIV case surveillance through the use of non-name unique identifiers—Maryland and Texas, 1994–1996. MMWR 1998;46:1254–8,1271.

Council of State and Territorial Epidemiologists. CSTE: position statement ID-4. National HIV surveillance: addition to the National Public Health Surveillance System. Atlanta, Georgia: Council of State and Territorial Epidemiologists, 1997.

Dear Colleague Letter from Julie Louise Gerberding, Director of CDC, July 5, 2005.

Grandfathering

Question 4. Dr. Duke, although I agree that the currently funded title 1 cities have been providing key infrastructure for AIDS care for some time, one of the key White House principles for the reauthorization of Ryan White is to eliminate the grandfathered EMAs. Currently, metropolitan areas continue to receive funding in perpetuity, regardless of whether those metropolitan areas would still be eligible for funding. According to the GAO, in 2004, 57 percent of the current metropolitan areas would not be eligible under current eligibility requirements. These areas received over $116 M in funding in 1 year alone! Obviously, the Administration has acknowledged issues in this area, given your desire to eliminate those who would no longer be eligible. Can you further describe how you would envision doing this? What sort of transition seems appropriate to you?

Answer 4. Under Title I of the 1990 Ryan White CARE Act, metropolitan areas eligible for funding had to meet one of two criteria: (1) 2000 AIDS cases; or (2) a per capita incidence of cumulative cases not less than 0.0025. The per capita incidence criteria, removed in 1996, established many of the smaller EMAs funded in 1990. The 1996 CARE Act Amendments attempted to further target funding to larger EMAs by replacing the per capita incidence criteria with language limiting funding to areas with a population of at least 500,000 and limiting the threshold of 2,000 cases to the most recent period of 5 calendar years. At the same time, however, a "grandfather" clause was established in the CARE Act Amendments of 1996 which allowed metropolitan areas eligible for funding in fiscal year 1996 to remain eligible even if their reported number of AIDS cases dropped below the case threshold. There are currently 29 EMAs that are no longer meeting the current eligibility criteria and are protected by the grandfather clause. The number of reported AIDS cases for the most recent 5-year period in these 29 EMAs ranged from 223 to 1,941 cases.

Testing

Question 5. Some have suggested that the Administration only focuses on testing, given the new Domestic HIV/AIDS initiative. However, CDC spends quite a bit of money outside that initiative for HIV prevention. Can you discuss what other things are funded by CDC each year in these activities to give a better context as to why the current new proposal focuses on testing?

Answer 5. To have the largest impact on the HIV epidemic, CDC utilizes a comprehensive approach to HIV prevention. Comprehensive HIV prevention is a broad term that incorporates surveillance, research, prevention interventions and evaluation. CDC's surveillance and research activities help to better define and understand the HIV/AIDS epidemic across the Nation. CDC's prevention interventions and capacity building efforts are based on behavioral, laboratory and medical science and work to contain the spread of HIV and AIDS. Program evaluation and policy research and development assess intervention effectiveness and refine prevention approaches. Additional information about CDC's comprehensive approach to HIV prevention is contained in the attached fact sheet, "Comprehensive HIV Prevention."

In fiscal year 2006, CDC received $651.1 million for domestic HIV/AIDS prevention activities conducted by the National Center for HIV, STD, and TB Prevention. It is estimated that 14 percent of this total will be spent on surveillance activities; 9 percent on prevention research; 9 percent on capacity building/technical assistance efforts; 63 percent on intervention activities including testing programs and other prevention activities carried out by State, local and community-based organizations (CBOs); and 5 percent on program evaluation and policy development. An additional $68.6 million will be spent CDC-wide on efforts such as HIV school health education, safe motherhood, hemophilia programs, and preventing nosocomial transmission. The vast majority of CDC's domestic HIV/AIDS funding is spent extramurally through cooperative agreements to private-sector, State and local health departments, education agencies, non-governmental organizations, and CBOs.

For fiscal year 2007, we have proposed expanding our HIV testing efforts. HIV testing is an integral part of CDC's HIV prevention strategy, as knowledge of one's HIV infection can help prevent spread of the infection to others. Studies have shown that when people know that they are infected with HIV, they are significantly more likely to protect their partners from infection than when they were unaware of their infection. We think that this initiative will identify a large number of previously undiagnosed cases, and help link those persons to care, treatment and counseling, and avoid transmitting HIV to others.

Core Medical Services

Question 6. Dr. Duke, I find it rather appalling that some States spend less than 25 percent of their Ryan White dollars on "core medical services," while other States are struggling to provide key medical care to individuals. In addition, only seven metropolitan areas receiving special Ryan White funds spent 75 percent or more on health care services. The rest may be spent on support services, such as buddy/companion services. Meanwhile 1,043 individuals with HIV/AIDS are awaiting life-saving prescription drugs. I applaud you for your efforts to focus Ryan White on providing care that will save lives. Can you outline how you would generally want to implement the requirement for 75 percent of funds to be spent on these services? Would this implementation be difficult, given HRSA's current accounting process?

Answer 6. Both title I and title II program guidance describe the elements of a continuum of care and utilize the term "core services." In the 2005 title I guidance, grantees were asked to prioritize essential core services, describe the priority setting and allocations processes and how data were used in this process to increase access to core services. Grantees were also asked to justify other sources of core services if funds are not allocated to these services. For the top services they identified, including core services, grantees were asked to develop one or more service goals for each priority with time—limited and measurable program objectives.

Title III utilizes the terminology primary care services, which is essentially equivalent to core services. At the present time, 82 percent of title III dollars are spent on these "core services." Title IV grantees are aware of the proposed changes, both through HRSA efforts as well as through the efforts of the national constituency organizations. HRSA will continue to promote the anticipated implementation of these changes.

Double Counting

Question 7. Dr. Duke, I applaud the Administration's proposal to more fairly count the HIV cases by eliminating "double counting." As you are aware, the current Ryan White formulas allow a person living in certain metropolitan areas to be counted twice—one as part of the title 1 funds and partially counted as part of the title 2 funds. Do you see the elimination of double counting as a mechanism to provide more fairness to the Ryan White formulas? Can you highlight some of the disparities in funding now due to this requirement?

Answer 7. We see the elimination of double counting as a mechanism to provide more equitable distribution of CARE Act Funds. The recent GAO report, "Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds," illustrated the effect of counting EMA cases twice by comparing the relationship between the percentage of a States' estimated living cases that are within EMAs and the amount of total title I and title II funding they receive per ELC. The Table presented below shows that as the percentage of a State's or Puerto Rico's ELCs within EMAs increases, the total title I and II funding per ELC also increases. For example, States with no ELCs in EMAs received on average $3,592 per ELC. States with 75 percent or more of their cases in EMAs and Puerto Rico received on average $4,995 per ELC, or 38 percent more funding than States with no EMA. If the total title I and title II funding had been distributed proportionally per ELC among all States and Puerto Rico, each grantee would have received $4,782 per ELC.

Relationship Between ELCs in EMAs and Total CARE Act Title I and II

Funding per ELC, Fiscal Year 2004

Percentage of States' and Puerto Rico's ELCs in EMAs	Average funding per ELC
None	$3,592
Less than 50 percent	$3,954
50 to 75 percent	$4,717
More than 75 percent	$4,955

Source: GAO analysis of HRSA data.

QUESTIONS OF SENATOR KENNEDY

Question 1. I am looking for some information on what was done with HRSA funding in fiscal year 2005. Specifically, I am looking for a state-by-state breakdown for fiscal year 2005 health professions grants—a cumulative total, as well as Bureau of Primary Health Care grants (including migrant health centers, community health centers, school-based health, and integrated services development initiative among others). This information is not yet posted on the HRSA Web site. In past years I

believe it has been table 9E of the Uniform Data System. Can you provide this to my office in a timely manner?

Answer 1. Spreadsheets are attached.

BHPr State by State Grant Report for Fiscal Year 2005

State	Program Name	# of Grants	Total # of Dollars
Alabama	Advanced Education Nursing Grants	2	$1,748,891.00
	Advanced Education Nursing Traineeship	6	546,285.00
	Centers of Excellence	1	2,547,562.00
	Graduate Geropsychology Education Program	1	206,905.00
	Health Administration Traineeships and Special Projects	1	47,102.00
	Health Careers Opportunity Program	3	1,690,850.00
	Nurse Anesthetist Traineeships	1	45,099.00
	Nurse Education Practice and Retention	3	828,840.00
	Nurse Education, Practice and Retention: Career Ladder	1	562,826.00
	Nursing Workforce Diversity	1	284,556.00
	Physician Assistant Training in Primary Care	1	199,325.00
	Pre-Doctoral Training in Primary Care	1	133,278.00
	Public Health Traineeship	1	60,455.00
	Residency Training in General and Pediatric Dentistry	1	165,598.00
	Residency Training in Primary Care	1	163,713.00
	Scholarships for Disadvantaged Students	6	562,893.00
Totals for AL		31	$9,794,178.00
Alaska	Advanced Education Nursing Traineeship	1	$36,192.00
	Basic/Core Area Health Education Centers	1	763,713.00
	Geriatric Education Centers	1	412,037.00
	Health Careers Opportunity Program	1	149,063.00
	Nurse Education, Practice, and Retention: Internship and Residency Programs.	1	156,206.00
	Quentin N. Burdick Program For Rural Interdisciplinary Training	1	267,417.00
	Residency Training in General and Pediatric Dentistry	1	209,012.00
Totals for AK		7	$1,993,640.00
Arizona	Academic Administrative Units in Primary Care	1	$201,293.00
	Advanced Education Nursing Grants	2	2,114,188.00
	Advanced Education Nursing Traineeship	3	162,033.00
	Allied Health Projects	1	151,227.00
	Centers of Excellence	1	500,000.00
	Faculty Development in Primary Care	1	187,137.00
	Geriatric Education Centers	1	399,350.00
	Grants to States for Loan Repayment	1	40,194.00
	Health Administration Traineeships and Special Projects	1	11,387.00
	Health Education and Training Centers	1	166,558.00
	Model State-Supported Area Health Education Centers	1	412,940.00
	Nurse Education, Practice and Retention: Career Ladder	1	190,845.00
	Nursing Workforce Diversity	2	505,465.00
	Pathways to Health Professions	1	107,645.00
	Pre-Doctoral Training in Primary Care	2	340,924.00
	Quentin N. Burdick Program For Rural Interdisciplinary Training	1	266,355.00
	Residency Training in Primary Care	1	124,200.00
	Scholarships for Disadvantaged Students	3	330,316.00
Totals for AZ		25	$6,212,057.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
Arkansas	Advanced Education Nursing Grants	1	$212,299.00
	Advanced Education Nursing Traineeship	3	116,018.00
	Faculty Development in Primary Care	1	133,301.00
	Geriatric Education Centers	1	424,380.00
	Health Administration Traineeships and Special Projects	1	21,739.00
	Health Careers Opportunity Program	1	419,278.00
	Health Education Training Centers	1	315,471.00
	Model State-Supported Area Health Education Centers	1	495,528.00
	Nurse Anesthetist Traineeships	1	6,769.00
	Nurse Education, Practice and Retention: Career Ladder	1	108,000.00
	Nursing Workforce Diversity	1	271,852.00
	Pre-Doctoral Training in Primary Care	1	160,043.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	261,138.00
	Residency Training in Primary Care	1	216,849.00
	Scholarships for Disadvantaged Students	4	142,461.00
Totals for AR		20	$3,305,126.00
California	Academic Administrative Units in Primary Care	4	$988,253.00
	Advanced Education Nursing Grants	3	$1,875,254.00
	Advanced Education Nursing Traineeship	17	1,370,794.00
	Allied Health Projects	1	175,924.00
	Bioterriorism Training and Curriculum Development Program	2	1,599,970.00
	Center for Health Workforce	1	250,000.00
	Centers for Excellence	4	3,059,127.00
	Dental Public Health Residency Training Grants	1	99,622.00
	Faculty Development in Primary Care	5	2,178,239.00
	Geriatric Education Centers	3	1,069,588.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	2	1,431,130.00
	Graduate Psychology Education Programs	1	103,702.00
	Grants to States for Loan Repayment	1	452,098.00
	Health Administration Traineeships and Special Projects	1	40,425.00
	Health Careers Opportunity Program	4	2,964,305.00
	Health Education Training Centers	1	503,312.00
	Model State-Supported Area Health Education Centers	1	908,457.00
	NRSA for Primary Medical Care	2	884,968.00
	Nurse Anesthetist Traineeships	3	49,779.00
	Nurse Education Practice and Retention	1	669,579.00
	Nurse Education, Practice and Retention: Career Ladder	5	1,551,221.00
	Nurse Education, Practice and Retention: Enhancing Patient Care Delivery Systems.	1	274,655.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	4	885,122.00
	Nursing Workforce Diversity	3	968,699.00
	Other Health Professions Programs (Earmarks)	4	1,415,816.00
	Physician Assistant Training in Primary Care	5	921,468.00
	Pre-Doctoral Training in Primary Care	6	983,305.00
	Preventive Medicine Residencies	1	157,191.00
	Public Health Traineeship	3	92,194.00
	Public Health Training Centers	1	366,315.00
	Residency Training in General and Pediatric Dentistry	1	435,689.00
	Residency Training in Primary Care	11	2,761,417.00
	Scholarships for Disadvantaged Students	17	5,919,468.00
Totals for CA		120	$37,407,086.00
Colorado	Academic Administrative Units in Primary Care	1	$257,234.00
	Advanced Education Nursing Grants	1	203,582.00
	Advanced Education Nursing Traineeship	3	346,999.00
	Bioterrorism Training and Curriculum Development Program	1	684,510.00
	Faculty Development in Primary Care	1	600,235.00
	Graduate Psychology Education Programs	1	161,106.00
	Grants to States for Loan Repayment	1	46,668.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Health Administration Traineeships and Special Projects	1	61,595.00
	Model State-Supported Area Health Education Centers	1	412,940.00
	NRSA for Primary Medical Care	1	291,688.00
	Nurse Education, Practice and Retention	1	301,298.00
	Nurse Education, Practice and Retention: Enhancing Patient Care Delivery Systems.	1	190,601.00
	Physician Assistant Training in Primary Care	1	190,685.00
	Pre-Doctoral Training in Primary Care	2	429,334.00
	Preventive Medicine Residencies	1	164,509.00
	Public Health Traineeship	1	9,236.00
	Residency Training in Primary Care	2	497,662.00
	Scholarships for Disadvantaged Students	2	380,062.00
Totals for CO.			
Connecticut	Advanced Education Nursing Grants	1	$215,799.00
	Advanced Education Nursing Traineeship	5	242,170.00
	Bioterrorism Training and Curriculum Development Program	2	1,577,130.00
	Faculty Development in Primary Care	1	96,859.00
	Graduate Psychology Education Programs	1	148,232.00
	Grants to States for Loan Repayment	1	5,000.00
	Grow Your Own FQHC Nurse	1	75,000.00
	Health Careers Opportunity Program	1	673,795.00
	Model State-Supported Area Health Education Centers	1	330,352.00
	Nurse Anesthetist Traineeships	1	9,044.00
	Physician Assistant Training in Primary Care	1	158,463.00
	Pre-Doctoral Training in Primary Care	1	191,244.00
	Preventive Medicine Residencies	1	133,739.00
	Public Health Traineeship	1	38,288.00
	Residency Training in General and Pediatric Dentistry	1	298,794.00
	Residency Training in Primary Care	1	150,377.00
	Scholarships for Disadvantaged Students	1	97,105.00
Totals for CT		22	$4,441,391.00
Delaware	Advanced Education Nursing Traineeship	3	$122,430.00
	Faculty Development in Primary Care	1	299,898.00
	Graduate Psychology Education Programs	1	138,086.00
	Grants to States for Loan Repayment	1	32,413.00
	Scholarships for Disadvantaged Students	1	188,932.00
Totals for DE		7	$781,759.00
District of Columbia	Academic Administrative Units in Primary Care	1	$310,226.00
	Advanced Education Nursing Grants	1	764,557.00
	Advanced Education Nursing Traineeship	1	93,844.00
	ASPH Cooperative Agreement	1	343,694.00
	Basic/Core Area Health Education Centers	1	456,156.00
	Centers of Excellence	1	582,433.00
	Faculty Development in Primary Care	1	607,791.00
	Geriatric Education Centers	1	310,879.00
	Graduate Psychology Education Programs	1	157,845.00
	Health Careers Opportunity Program	1	875,810.00
	Minority Faculty Fellowships	1	54,604.00
	Nurse Anesthetist Traineeships	1	32,243.00
	Nurse Education, Practice and Retention: Career Ladder	1	157,124.00
	Nurse Education, Practice and Retention: Enhancing Patient Care Delivery Systems.	1	309,395.00
	Nursing Workforce Diversity	1	1,068,870.00
	Other Health Professions Programs (Earmarks)	1	496,000.00
	Pre-Doctoral Training in Primary Care	1	162,000.00
	Public Health Training Centers	1	926,864.00
	Residency Training in General and Pediatric Dentistry	1	619,937.00
	Residency Training in Primary Care	1	202,657.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Scholarships for Disadvantaged Students	1	470,989.00
Totals for DC		21	$9,003,918.00
Florida	Academic Administrative Units in Primary Care	1	$190,633.00
	Advanced Education Nursing Grants	5	1,284,847.00
	Advanced Education Nursing Traineeship	11	771,866.00
	Allied Health Projects	1	140,722.00
	Bioterrorism Training and Curriculum Development Program	2	1,724,076.00
	Comprehensive Geriatric Education Program	1	50,000.00
	Dental Public Health Residency Training Grants	1	92,457.00
	Geriatric Education Centers	3	926,329.00
	Graduate Geropsychology Education Program	1	220,643.00
	Graduate Psychology Education Programs	1	167,341.00
	Health Administration Traineeships and Special Projects	1	16,512.00
	Health Careers Opportunity Program	5	1,718,926.00
	Health Education Training Centers	1	556,010.00
	Model State-Supported Area Health Education Centers	4	879,070.00
	Nurse Anesthetist Traineeships	4	63,590.00
	Nurse Education Practice and Retention	1	222,196.00
	Nurse Education, Practice and Retention: Career Ladder	2	515,555.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	129,775.00
	Nursing Workforce Diversity	1	282,726.00
	Pathways to Health Professions	1	94,752.00
	Physician Assistant Training in Primary Care	1	162,918.00
	Podiatric Residency Training in Primary Care	1	200,876.00
	Pre-Doctoral Training in Primary Care	2	305,640.00
	Public Health Traineeship	2	36,776.00
	Residency Training in General and Pediatric Dentistry	1	236,278.00
	Residency Training in Primary Care	3	408,240.00
	Scholarships for Disadvantaged Students	11	2,527,180.00
Totals for FL		69	$13,925,934.00
Georgia	Academic Administrative Units in Primary Care	1	$221,288.00
	Advanced Education Nursing Grants	5	2,222,989.00
	Advanced Education Nursing Traineeship	10	357,941.00
	Bioterriorism Training and Curriculum Development Program	1	1,499,269.00
	Centers of Excellence	1	586,479.00
	Faculty Development in Primary Care	2	608,417.00
	Geriatric Education Centers	1	341,665.00
	Graduate Psychology Education Programs	1	131,905.00
	Grants to States for Loan Repayment	1	75,625.00
	Health Careers Opportunity Program	3	1,124,581.00
	Health Education and Training Centers	1	315,000.00
	Model State-Supported Area Health Education Centers	2	578,113.00
	Nurse Anesthetist Traineeships	1	12,152.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	252,041.00
	Nursing Workforce Diversity	1	192,208.00
	Pathways to Health Professions	1	50,424.00
	Physician Assistant Training in Primary Care	1	62,861.00
	Pre-Doctoral Training in Primary Care	2	615,703.00
	Preventive Medicine Residencies	1	187,201.00
	Public Health Traineeship	1	30,059.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	348,692.00
	Residency Training in Primary Care	3	580,793.00
	Scholarships for Disadvantaged Students	4	1,274,718.00
Totals for GA		46	$11,670,124.00
Hawaii	Advanced Education Nursing Grants	1	$691,777.00
	Advanced Education Nursing Traineeship	2	77,400.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Allied Health Projects	1	181,130.00
	Basic/Core Area Health Education Centers	1	1,240,774.00
	Bioterrorism Training and Curriculum Development Program	1	1,648,271.00
	Centers of Excellence	1	741,029.00
	Comprehensive Geriatric Education Program	1	120,840.00
	Cooperative Agreement to Plan, Develop & Operate a Continuing Clinical Education Program in Pacific Basin.	1	385,179.00
	Faculty Development in Primary Care	1	378,252.00
	Geriatric Education Centers	1	431,280.00
	Health Education Training Centers	1	239,508.00
	Nurse Education, Practice and Retention	1	208,494.00
	Pre-Doctoral Training in Primary Care	1	149,242.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	336,227.00
	Scholarships for Disadvantaged Students	1	59,085.00
Totals for HI		16	$6,888,488.00
Idaho	Advanced Education Nursing Traineeship	1	$27,051.00
	Bioterrorism Training and Curriculum Development Program	1	1,287,901.00
	Nurse Education Practice and Retention	1	234,582.00
	Other Health Professions Programs (Earmarks)	1	245,516.00
	Physician Assistant Training in Primary Care	1	150,206.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	277,668.00
	Residency Training in General and Pediatric Dentistry	1	369,197.00
	Residency Training in Primary Care	2	415,651.00
	Scholarships for Disadvantaged Students	2	348,481.00
Totals for ID		11	$3,356,253.00
Illinois	Academic Administrative Units in Primary Care	1	$187,920.00
	Advanced Education Nursing Grants	4	2,549,587.00
	Advanced Education Nursing Traineeship	10	604,921.00
	Allied Health Projects	2	246,566.00
	Bioterrorism Training and Curriculum Development Program	3	2,396,412.00
	Center for Health Workforce	1	250,000.00
	Centers of Excellence	1	570,841.00
	Comprehensive Geriatric Education Program	2	264,109.00
	Faculty Development in Primary Care	1	817,697.00
	Geriatric Education Centers	1	214,347.00
	Graduate Geropsychology Education Program	2	170, 326.00
	Grants to States for Loan Repayment	1	149,323.00
	Health Administration Traineeships and Special Projects	2	75,053.00
	Health Careers Opportunity Program	1	661,745.00
	Model State-Supported Area Health Education Centers	1	330,352.00
	Nurse Anesthetist Traineeships	4	70,302.00
	Nurse Education Practice and Retention	2	474,191.00
	Nurse Education, Practice and Retention: Career Ladder	2	555,790.00
	Nurse Education, Practice and Retention: Enhancing Patient Care Delivery Systems.	2	666,170.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	2	354,754.00
	Nursing Workforce Diversity	2	482,151.00
	Physician Assistant Training in Primary Care	2	349,980.00
	Pre-Doctoral Training in Primary Care	2	454,254.00
	Public Health Traineeship	1	71,370.00
	Public Health Training Centers	1	270,507.00
	Residency Training in General and Pediatric Dentistry	1	306,189.00
	Residency Training in Primary Care	3	864,788.00
	Scholarships for Disadvantaged Students	7	984,821.00
Totals for IL		64	$15,394,466.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
Indiana	Advanced Education Nursing Grants	2	$347,638.00
	Advanced Education Nursing Traineeship	7	354,094.00
	Basic/Core Area Health Education Centers	1	1,215,105.00
	Grants to States for Loan Repayment	1	59,306.00
	Nurse Education, Practice and Retention: Career Ladder	2	279,080.00
	Residency Training in Primary Care	1	216,000.00
	Scholarships for Disadvantaged Students	5	693,823.00
Totals for IN		19	$3,165,046.00
Iowa	Advanced Education Nursing Traineeship	3	$119,872.00
	Center for Health Workforce	1	457,780.00
	Chiropractic Demonstration Projects	1	369,572.00
	Dental Public Health Residency Training Grants	1	159,714.00
	Faculty Development in Primary Care	1	157,428.00
	Geriatric Education Centers	2	694,761.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	483,507.00
	Grants to States for Loan Repayment	1	138,050.00
	Nurse Anesthetist Traineeships	1	8,707.00
	Nurse Education, Practice and Retention: Enhancing Patient Care Delivery Systems.	1	230,592.00
	Other Health Professions Programs (Earmark)	2	1,671,498.00
	Pre-Doctoral Training in Primary Care	1	138,172.00
	Public Health Traineeship	1	22,838.00
	Public Health Training Centers	1	421,704.00
	Scholarships for Disadvantaged Students	3	421,193.00
Totals for IA		21	$5,495,388.00
Kansas	Academic Administrative Units in Primary Care	2	$314,650.00
	Advanced Education Nursing Traineeship	4	166,368.00
	Bioterrorism Training and Curriculum Development Program	1	1,427,903.00
	Centers for Excellence	1	1,274,870.00
	Comprehensive Geriatric Education Program	1	192,161.00
	Faculty Development in Primary Care	1	544,911.00
	Geriatric Education Centers	1	396,363.00
	Grants to States for Loan Repayment	1	5,000.00
	Health Administration Traineeships and Special Projects	1	28,986.00
	Health Careers Opportunity Program	1	819,412.00
	Nurse Anesthetist Traineeships	2	23,874.00
	Nurse Education, Practice and Retention: Career Ladder	1	227,134.00
	Physician Assistant Training in Primary Care	1	220,329.00
	Pre-Doctoral Training in Primary Care	1	368,264.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	325,960.00
	Residency Training in Primary Care	1	248,350.00
	Scholarships for Disadvantaged Students	1	75,533.00
Totals for KS		22	$6,660,068.00
Kentucky	Academic Administrative Units in Primary Care	1	$205,200.00
	Advanced Education Nursing Grants	2	552,709.00
	Advanced Education Nursing Traineeship	7	423,268.00
	Allied Health Projects	2	482,037.00
	Bioterrorism Training and Curriculum Development Program	1	1,078,164.00
	Faculty Development in Primary Care	1	413,767.00
	Geriatric Education Centers	1	414,560.00
	Graduate Psychology Education Programs	1	156,600.00
	Grants to States for Loan Repayment	1	5,000.00
	Health Administration Traineeships and Special Projects	1	15,011.00
	Health Careers Opportunity Program	2	677,319.00
	Health Education Training Centers	1	347,864.00
	Model State-Supported Area Health Education Centers	1	660,704.00
	Nurse Anesthetist Traineeships	1	4,091.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Nurse Education, Practice and Retention: Career Ladder	2	428,527.00
	Nurse Education, Practice, and Retention: Enhancing Patient Care Delivery Systems.	1	205,978.00
	Nursing Workforce Diversity	2	579,751.00
	Physician Assistant Training in Primary Care	1	179,038.00
	Pre-Doctoral Training in Primary Care	1	352,391.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	348,035.00
	Residency Training in General and Pediatric Dentistry	1	495,795.00
	Residency Training in Primary Care	2	513,472.00
	Scholarships for Disadvantaged Students	3	138,656.00
Totals for KY		37	$8,677,937.00
Louisiana	Advanced Education Nursing Grants	1	$179,541.00
	Advanced Education Nursing Traineeship	7	316,796.00
	Allied Health Projects	1	105,403.00
	Center of Excellence	1	2,280,000.00
	Faculty Development in Primary Care	2	553,022.00
	Grants to States for Loan Repayment	1	275,000.00
	Health Careers Opportunity Program	1	486,974.00
	Model State-Supported Area Health Education Centers	2	330,352.00
	Nurse Anesthetist Traineeships	1	38,057.00
	Nursing Workforce Diversity	2	563,618.00
	Pathways to Health Professions	1	97,315.00
	Pre-Doctoral Training in Primary Care	1	178,425.00
	Public Health Traineeship	1	114,360.00
	Public Health Training Centers	1	381,308.00
	Residency Training in General and Pediatric Dentistry	1	386,573.00
	Residency Training in Primary Care	1	48,183.00
	Scholarships for Disadvantaged Students	5	1,286,012.00
Totals for LA		30	$7,620,939.00
Maine	Advanced Education Nursing Traineeship	3	$107,350.00
	Geriatric Education Centers	1	198,628.00
	Grants to State for Loan Repayment	1	89,375.00
	Model State-Supported Area Health Education Centers	1	247,764.00
	Nurse Anesthetist Traineeships	1	7,752.00
	Nurse Education Practice and Retention	1	257,000.00
	Physician Assistant Training in Primary Care	1	89,119.00
	Scholarships for Disadvantaged Student	1	6,748.00
Totals for ME		10	$1,003,736.00
Maryland	Advanced Education Nursing Grants	1	$598,579.00
	Advanced Education Nursing Traineeship	3	322,336.00
	Allied Health Projects	3	469,331.00
	Comprehensive Geriatric Education Program	1	174,216.00
	Faculty Development in Primary Care	1	1,676,458.00
	Geriatric Education Centers	1	162,000.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	326,846.00
	Grants to States for Loan Repayment	1	200,000.00
	Health Careers Opportunity Program	1	499,524.00
	Model State-Supported Area Health Education Centers	1	247,761.00
	NRSA for Primary Medical Care	1	633,140.00
	Nurse Anesthetist Traineeships	1	431.00
	Nurse Education, Practice and Retention: Career Ladder	1	265,224.00
	Nursing Workforce Diversity	1	396,876.00
	Other Health Professions Programs (Earmarks)	2	540,134.00
	Preventive Medicine Residencies	1	523,943.00
	Public Health Traineeship	1	126,619.00
	Public Health Training Centers	1	295,906.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	243,729.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Residency Training in Primary Care	1	208,209.00
	Scholarships for Disadvantaged Students	3	676,259.00
Totals for MD		28	$8,587,521.00
Massachusetts	Academic Administrative Units in Primary Care	2	$829,520.00
	Advanced Education Nursing Grants	2	889,640.00
	Advanced Education Nursing Traineeships	7	563,244.00
	Dental Public Health Residency Training Grants	1	133,299.00
	Faculty Development in Primary Care	2	1,184,454.00
	Geriatric Education Centers	1	397,949.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	1,174,994.00
	Graduate Psychology Education Programs	1	243,251.00
	Grants to States for Loan Repayment	1	140,220.00
	Health Administration Traineeships and Special Projects	1	35,715.00
	Health Careers Opportunity Program	2	608,509.00
	Model State-Supported Area Health Education Centers	1	495,528.00
	NRSA for Primary Medical Care	2	2,074,241.00
	Nurse Anesthetist Traineeships	2	23,844.00
	Nurse Education, Practice and Retention: Career Ladder	1	180,587.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	270,000.00
	Nurse Workforce Diversity	3	750,863.00
	Pre-Doctoral Training in Primary Care	2	520,846.00
	Public Health Traineeship	3	143,917.00
	Public Health Training Centers	1	331,450.00
	Residency Training in General and Pediatric Dentistry	3	507,356.00
	Residency Training in Primary Care	1	358,057.00
	Scholarships for Disadvantaged Students	5	840,379.00
Totals for MA		46	$12,697,863.00
Michigan	Academic Administrative Units in Primary Care	3	$1,019,822.00
	Advanced Education Nursing Grants	1	246,468.00
	Advanced Education Nursing Traineeship	7	366,576.00
	Basic/Core Area Health Education Centers	1	1,187,445.00
	Bioterrorism Training and Curriculum Development Program	1	100,000.00
	Centers of Excellence	1	801,812.00
	Comprehensive Geriatric Education Program	2	206,343.00
	Faculty Development in Primary Care	1	534,556.00
	Geriatric Education Centers	1	$323,798.00
	Grants to States for Loan Repayment	1	620,822.00
	Health Careers Opportunity Program	3	2,513,183.00
	Nurse Anesthetist Traineeship	3	83,745.00
	Nurse Education Practice and Retention	2	352,530.00
	Nurse Education Practice and Retention: Career Ladder	1	241,479.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	239,569.00
	Nursing Workforce Diversity	3	618,800.00
	Pre-Doctoral Training in Primary Care	1	434,375.00
	Public Health Traineeship	1	122,421.00
	Public Health Training Centers	1	403,161.00
	Scholarships for Disadvantaged Students	6	729,886.00
Totals for MI		41	$11,146,791.00
Minnesota		2	$637,167.00
	Advanced Education Nursing Grants	2	562,131.00
	Advanced Education Nursing Traineeship	5	252,744.00
	Basic/Core Area Health Education Centers	1	700,767.00
	Bioterrorism Training and Curriculum Development Program	1	878,251.00
	Centers of Excellence	1	492,077.00
	Chiropractic Demonstration Projects	1	938,256.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Faculty Development in Primary Care	1	742,300.00
	Geriatric Education Centers	1	360,000.00
	Grants to States for Loan Repayment	1	82,500.00
	Health Administration Traineeships and Special Projects	1	27,951.00
	Health Careers Opportunity Program	1	358,294.00
	Nurse Anesthetist Traineeships	2	34,670.00
	Nurse Education Practice and Retention: Career Ladder	1	143,357.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	174,488.00
	Other Health Professions Programs (Earmarks)	2	437,020.00
	Pre-Doctoral Training in Primary Care	1	97,200.00
	Public Health Traineeship	1	54,409.00
	Public Health Training Centers	1	353,111.00
	Scholarships for Disadvantaged Students	1	64,210.00
Totals for MN		28	$7,390,903.00
Mississippi	Advanced Education Nursing Traineeship	5	$214,871.00
	Basic/Core Area Health Education Centers	1	884,095.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	232,056.00
	Pre-Doctoral Training in Primary Care	1	147,333.00
	Public Health Traineeship	1	9,572.00
	Residency Training in General and Pediatric Dentistry	1	110,569.00
	Scholarships for Disadvantaged Students	3	1,398,847.00
Totals for MS		13	$2,997,343.00
Missouri	Academic Administrative Units in Primary Care	2	$340,582.00
	Advanced Education Nursing Grants	2	407,317.00
	Advanced Education Nursing Traineeship	8	401,062.00
	Basic/Core Area Health Education Centers	1	122,863.00
	Bioterrorism Training and Curriculum Development Program	1	193,181.00
	Comprehensive Geriatric Education Program	1	50,000.00
	Faculty Development in Primary Care	1	475,125.00
	Geriatric Education Centers	1	432,000.00
	Graduate Psychology Education Programs	2	326,125.00
	Grants to States for Loan Repayment	1	149,105.00
	Health Administration Traineeships and Special Projects	2	51,243.00
	Model State-Supported Area Health Education Centers	2	541,441.00
	Nurse Anesthetist Traineeships	2	28,367.00
	Nurse Education Practice and Retention: Career Ladder	1	250,442.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	191,052.00
	Nursing Workforce Diversity	2	399,943.00
	Physician Assistant Training in Primary Care	1	191,041.00
	Pre-Doctoral Training in Primary Care	1	135,000.00
	Public Health Traineeship	1	11,419.00
	Public Health Training Centers	1	232,284.00
	Residency Training in Primary Care	3	475,176.00
	Scholarships for Disadvantaged Students	3	252,532.00
Totals for MO		40	$5,657,300.00
Montana	Advanced Education Nursing Grants	1	$280,129.00
	Advanced Education Nursing Traineeship	1	27,152.00
	Bioterrorism Training and Curriculum Development Program	1	1,447,404.00
	Centers of Excellence	1	50,632.00
	Geriatric Education Centers	1	344,017.00
	Health Careers Opportunity Program	1	983,517.00
	Nursing Workforce Diversity	1	296,470.00
	Residency Training in Primary Care	1	56,700.00
	Scholarships for Disadvantaged Students	3	595,238.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
Totals for MT		11	$4,081,259.00
Nebraska	Academic Administrative Units in Primary Care	1	$74,414.00
	Advanced Education Nursing Grants	1	$262,792.00
	Advanced Education Nursing Traineeship	1	143,890.00
	Allied Health Projects	1	308,582.00
	Basic/Core Area Health Education Centers	1	1,965,151.00
	Bioterrorism Training and Curriculum Development Program	1	200,000.00
	Centers of Excellence	1	530,014.00
	Geriatric Education Centers	1	428,090.00
	Graduate Psychology Education Programs	1	160,316.00
	Health Careers Opportunity Program	1	482,478.00
	Nurse Anesthetist Traineeships	1	9,784.00
	Nurse Education Practice and Retention	1	388,052.00
	Physician Assistant Training in Primary Care	1	225,978.00
	Pre-Doctoral Training in Primary Care	1	77,812.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	203,298.00
	Residency Training in Primary Care	1	74,785.00
Totals for NE		16	$5,535,436.00
Nevada	Advanced Education Nursing Grants	1	$79,105.00
	Advanced Education Nursing Traineeship	2	51,884.00
	Bioterrorism Training and Curriculum Development Program	1	871,128.00
	Geriatric Education Centers	1	216,000.00
	Grants to States for Loan Repayment	1	5,000.00
	Model State-Supported Area Health Education Centers	1	165,174.00
	Other Health Professions Programs (Earmarks)	1	982,065.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	270,000.00
	Scholarships for Disadvantaged Students	2	76,649.00
Totals for NV		.....	$2,717,005.00
New Hampshire	Academic Administrative Units in Primary Care	1	$272,941.00
	Advanced Education Nursing Traineeship	1	54,443.00
	Faculty Development in Primary Care	2	127,715.00
	Grants to States for Loan Repayment	1	5,000.00
	Model State-Supported Area Health Education Centers	1	165,176.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	132,458.00
	Pre-Doctoral Training in Primary Care	1	276,754.00
	Residency Training in Primary Care	1	179,280.00
Totals for NH		.....	$1,213,767.00
New Jersey	Academic Administrative Units in Primary Care	3	$782,052.00
	Advanced Education Nursing Grants	4	1,272,337.00
	Advanced Education Nursing Traineeship	9	359,848.00
	Allied Health Projects	1	218,172.00
	Bioterrorism Training and Curriculum Development Program	1	1,428,590.00
	Centers of Excellence	1	608,065.00
	Comprehensive Geriatric Education Program	1	49,990.00
	Faculty Development in Primary Care	1	348,019.00
	Geriatric Education Centers	1	431,805.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	371,737.00
	Graduate Psychology Education Programs	1	96,615.00
	Grants to States for Loan Repayment	1	33,247.00
	Health Careers Opportunity Program	3	1,092,069.00
	Model State-Supported Area Health Education Centers	1	247,761.00
	NRSA for Primary Medical Care	1	269,927.00
	Nurse Anesthetist Traineeships	1	22,984.00
	Nurse Education Practice and Retention	1	199,367.00
	Nurse Education Practice and Retention: Career Ladder	2	757,609.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Other Health Professions Programs (Earmarks)	1	73,655.00
	Pre-Doctoral Training in Primary Care	3	687,374.00
	Public Health Traineeship	1	16,793.00
	Residency Training in Primary Care	2	554,800.00
	Scholarships for Disadvantaged Students	4	1,301,854.00
Totals for NJ			$11,219,670.00
New Mexico	Academic Administrative Units in Primary Care	1	$266,673.00
	Advanced Education Nursing Grants	1	362,504.00
	Advanced Education Nursing Traineeship	2	91,727.00
	Bioterrorism Training and Curriculum Development Program	1	1,491,550.00
	Centers of Excellence	1	632,987.00
	Geriatric Education Centers	1	323,917.00
	Graduate Psychology Education Programs	1	140,775.00
	Grants to States for Loan Repayment	1	87,044.00
	Health Careers Opportunity Program	1	484,573.00
	Health Education Training Centers	1	100,000.00
	Model State-Supported Area Health Education Center	1	165,174.00
	Nurse Education Practice and Retention	1	193,176.00
	Nurse Education Practice and Retention: Career Ladder	1	342,746.00
	Physician Assistant Training in Primary Care	1	151,661.00
	Pre-Doctoral Training in Primary Care	1	205,988.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	339,742.00
	Residency Training in General and Pediatric Dentistry	1	243,102.00
	Residency Training in Primary Care	1	181,354.00
	Scholarships for Disadvantaged Students	2	989,635.00
Totals for NM			$6,796,328.00
New York	Academic Administrative Units in Primary Care	5	$1,318,963.00
	Advanced Education Nursing Grants	4	2,201,758.00
	Advanced Education Nursing Traineeship	19	1,304,242.00
	Allied Health Projects	1	153,062.00
	Basic/Core Area Health Education Centers	1	2,582,605.00
	Bioterrorism Training and Curriculum Development Program	1	1,245,076.00
	Centers for Health Workforce	1	250,000.00
	Centers of Excellence	1	562,902.00
	Comprehensive Geriatric Education Program	3	268,698.00
	Dental Public Health Residency Training Grants	1	59,665.00
	Faculty Development in Primary Care	4	2,957,147.00
	Geriatric Education Centers	3	1,050,936.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	2	888,539.00
	Graduate Geropsychology Education Program	2	418, 586.00
	Graduate Psychology Education Programs	1	237,375.00
	Health Administration Traineeships and Special Projects	2	124,950.00
	Health Careers Opportunity Program	5	1,863,134.00
	NRSA for Primary Medical Care	2	464,078.00
	Nurse Anesthetist Traineeships	3	49,808.00
	Nurse Education Practice and Retention	3	1,573,304.00
	Nurse Education Practice and Retention: Career Ladder	1	297,161.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	500,712.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	610,322.00
	Nursing Workforce Diversity	3	1,311,236.00
	Other Health Professions Programs (Earmarks)	3	534,243.00
	Physician Assistant Training in Primary Care	3	778,929.00
	Pre-Doctoral Training in Primary Care	4	961,643.00
	Preventive Medicine Residencies	1	266,049.00
	Public Health Traineeship	2	119,231.00
	Public Health Training Centers	1	355,935.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	313,528.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Residency Training in General and Pediatric Dentistry	5	1,644,383.00
	Residency Training in Primary Care	8	2,021,474.00
	Scholarships for Disadvantaged Students	12	4,365,152.00
Total for NY			$33,654,853.00
North Carolina	Academic Administrative Units in Primary Care	2	$519,052.00
	Advanced Education Nursing Grants	4	1,405,683.00
	Advanced Education Nursing Traineeship	6	447,223.00
	Allied Health Projects	1	124,145.00
	Bioterrorism Training and Curriculum Development Program	1	197,334.00
	Centers for Health Workforce	1	250,000.00
	Comprehensive Geriatric Education Program	3	610,750.00
	Dental Public Health Residency Training Grants	1	1.00
	Faculty Development in Primary Care	1	502,421.00
	Geriatric Education Centers	1	148,310.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	541,559.00
	Health Careers Opportunity Program	4	1,714,486.00
	Model State-Supported Area Health Education Centers	1	743,292.00
	NRSA for Primary Medical Care	1	357,042.00
	Nurse Anesthetist Traineeships	4	63,561.00
	Nurse Education Practice and Retention	2	513,026.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	2	598,192.00
	Nursing Workforce Diversity	3	578,692.00
	Other Health Professions Programs (Earmarks)	1	343,723.00
	Physician Assistant Training in Primary Care	2	422,615.00
	Pre-Doctoral Training in Primary Care	3	498,903.00
	Public Health Traineeship	1	129,474.00
	Public Health Training Centers	1	381,832.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	419,937.00
	Residency Training in General and Pediatric Dentistry	1	133,826.00
	Residency Training in Primary Care	3	420,477.00
	Scholarships for Disadvantaged Students	5	1,204,263.00
	Technical and Non Financial Assistance	1	190,750.00
Total for NC			$13,460,569.00
North Dakota	Advanced Education Nursing Grants	1	$462,209.00
	Advanced Education Nursing Traineeship	2	54,342.00
	Geriatric Education Centers	1	427,695.00
	Graduate Psychology Education Programs	1	224,344.00
	Grants to States for Loan Repayment	1	20,000.00
	Health Careers Opportunity Program	2	898,134.00
	Nurse Anesthetist Traineeships	1	9,138.00
	Nursing Workforce Diversity	1	239,760.00
	Physician Assistant Training in Primary Care	1	132,952.00
	Pre-Doctoral Training in Primary Care	1	106,880.00
	Scholarships for Disadvantaged Students	1	48,553.00
Total for ND			$2,624,007.00
Ohio	Academic Administrative Units in Primary Care	5	$1,351,061.00
	Advanced Education Nursing Grants	4	1,159,267.00
	Advanced Education Nursing Traineeship	10	624,990.00
	Allied Health Projects	2	229,416.00
	Centers of Excellence	1	533,684.00
	Comprehensive Geriatric Education Program	1	197,315.00
	Faculty Development in Primary Care	3	660,179.00
	Geriatric Education Centers	1	421,488.00
	Grants to States for Loan Repayment	1	5,000.00
	Health Administration Traineeships and Special Projects	1	31,315.00
	Model State-Supported Area Health Education Centers	1	660,696.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	NRSA for Primary Medical Care	2	389,854.00
	Nurse Anesthetist Traineeships	2	43,226.00
	Nurse Education Practice and Retention	3	533,505.00
	Nurse Education Practice and Retention: Career Ladder	1	845,810.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	293,835.00
	Nursing Workforce Diversity	1	341,990.00
	Other Health Professions Programs (Earmarks)	1	98,206.00
	Physician Assistant Training in Primary Care	5	119,303.00
	Pre-Doctoral Training in Primary Care	1	834,427.00
	Public Health Traineeship	1	10,748.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	195,277.00
	Residency Training in General and Pediatric Dentistry	3	495,223.00
	Residency Training in Primary Care	3	630,971.00
	Scholarships for Disadvantaged Students	9	1,761,118.00
Total for OH			$13,221,091.00
Oklahoma	Academic Administrative Units in Primary Care	1	$473,128.00
	Advanced Education Nursing Grants	1	242,901.00
	Advanced Education Nursing Traineeship	1	79,687.00
	Centers of Excellence	1	520,170.00
	Geriatric Education Centers	1	244,194.00
	Grants to States for Loan Repayment	1	-
	Health Careers Opportunity Program	1	482,170.00
	Model State-Supported Area Health Education Centers	1	330,348.00
	Nurse Education Practice and Retention	2	468,603.00
	Nurse Education Practice and Retention: Career Ladder	2	388,498.00
	Nursing Workforce Diversity	2	490,176.00
	Public Health Traineeship	1	38,624.00
	Residency Training in Primary Care	1	215,367.00
	Scholarships for Disadvantaged Students	5	1,184,251.00
Totals for OK			$5,158,117.00
Oregon	Academic Administrative Units in Primary Care	1	$147,464.00
	Advanced Education Nursing Grants	1	1,209,024.00
	Advanced Education Nursing Traineeship	1	117,723.00
	Faculty Development in Primary Care	1	154,585.00
	Geriatric Education Centers	1	412,564.00
	Health Careers Opportunity Program	2	684,540.00
	Model State-Supported Area Health Education Centers	1	412,935.00
	Nurse Education Practice and Retention: Career Ladder	1	192,207.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	269,207.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	210,568.00
	Nursing Workforce Diversity	2	412,043.00
	Pre-Doctoral Training in Primary Care	1	121,495.00
	Residency Training in Primary Care	1	376,544.00
	Scholarships for Disadvantaged Students	1	123,833.00
Totals for OR			$4,845,441.00
Pennsylvania	Academic Administrative Units in Primary Care	1	$172,800.00
	Advanced Education Nursing Grants	5	1,560,248.00
	Advanced Education Nursing Traineeship	15	846,782.00
	Allied Health Projects	2	349, 885.00
	Bioterrorism Training and Curriculum Development Program	1	135,119.00
	Centers of Excellence	1	877,217.00
	Comprehensive Geriatric Education Program	2	207,563.00
	Faculty Development in Primary Care	3	1,684,192.00
	Geriatric Education Centers	2	1,091,624.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	418, 070.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Graduate Psychology Education Programs	1	124,788.00
	Grants to States for Loan Repayment	1	121,384.00
	Health Administration Traineeships and Special Projects	4	151,090.00
	Health Careers Opportunity Program	2	555,529.00
	Model State-Supported Area Health Education Centers	1	660,696.00
	NRSA for Primary Medical Care	1	426,441.00
	Nurse Anesthetist Traineeships	6	187,179.00
	Nursing Workforce Diversity	1	193,947.00
	Other Health Professions Programs (Earmarks)	2	73,657.00
	Physician Assistant Training in Primary Care	1	128,248.00
	Pre-Doctoral Training in Primary Care	3	882,254.00
	Public Health Traineeship	1	17,297.00
	Public Health Training Centers	1	301,375.00
	Residency Training in General and Pediatric Dentistry	1	75,748.00
	Residency Training in Primary Care	4	534,541.00
	Scholarships for Disadvantaged Students	5	2,456,271.00
Totals for PA			$14,233,946.00
Puerto Rico	Advanced Education Nursing Grants	1	$307,120.00
	Advanced Education Nursing Traineeship	4	105,816.00
	Centers of Excellence	1	1,281,731.00
	Faculty Development in Primary Care	1	157,529.00
	Geriatric Education Centers	1	180,000.00
	Nurse Anesthetist Traineeships	2	48,551.00
	Nursing Workforce Diversity	1	242,118.00
	Other Health Professions Programs (Earmarks)	1	343,723.00
	Pre-Doctoral Training in Primary Care	1	200,619.00
	Public Health Traineeship	1	28,716.00
	Residency Training in General and Pediatric Dentistry	1	464,770.00
	Residency Training in Primary Care	1	129,600.00
	Scholarships for Disadvantaged Students	7	4,034,604.00
Total for PR			$7,524,897.00
Rhode Island	Academic Administrative Units in Primary Care	1	$169,582.00
	Advanced Education Nursing Grants	1	249,878.00
	Advanced Education Nursing Traineeship	1	53,249.00
	Basic/Core Area Health Education Centers	1	747,768.00
	Faculty Development in Primary Care	1	198,222.00
	Geriatric Education Centers	1	431,998.00
	Grants to States for Loan Repayment	1	31,075.00
	Pre-Doctoral Training in Primary Care	1	132,579.00
	Residency Training in General and Pediatric Dentistry	1	191,488.00
	Residency Training in Primary Care	2	248,400.00
	Scholarships for Disadvantaged Students	1	142,421.00
Total for RI			$2,596,660.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
South Carolina	Academic Administrative Units in Primary Care	1	$427,262.00
	Advanced Education Nursing Grants	1	211,955.00
	Advanced Education Nursing Traineeship	3	164,732.00
	Allied Health Projects	1	214,390.00
	Bioterrorism Training and Curriculum Development Program	1	1,331,869.00
	Comprehensive Geriatric Education Program	1	50,000.00
	Faculty Development in Primary Care	1	599,640.00
	Geriatric Education Centers	1	303,188.00
	Graduate Psychology Education Programs	1	140,673.00
	Grants to States for Loan Repayment	1	5,000.00
	Health Administration Traineeships and Special Projects	1	36,232.00
	Model State-Supported Area Health Education Centers	1	330,352.00
	Nurse Anesthetist Traineeships	2	33,349.00
	Nurse Education Practice and Retention	2	836,031.00
	Nursing Workforce Diversity	2	673,063.00
	Physician Assistant Training in Primary Care	1	161,973.00
	Pre-Doctoral Training in Primary Care	1	176,267.00
	Public Health Traineeship	1	37,784.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	358,396.00
	Residency Training in Primary Care	1	177,150.00
	Scholarships for Disadvantaged Students	2	42,089.00
Totals for SC			$6,311,395.00
South Dakota	Advanced Education Nursing Grants	1	$266,972.00
	Advanced Education Nursing Traineeship	1	37,626.00
	Allied Health Projects	1	117,675.00
	Graduate Geropsychology Education Program	1	269,997.00
	Grants to States for Loan Repayment	1	20,000.00
	Nurse Education Practice and Retention: Career Ladder	2	388,716.00
	Physician Assistant Training in Primary Care	1	137,262.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	336,138.00
	Scholarships for Disadvantaged Students	4	399,133.00
Total for SD			$1,973,513.00
Tennessee	Academic Administrative Units in Primary Care	2	$499,010.00
	Advanced Education Nursing Grants	3	2,058,123.00
	Advanced Education Nursing Traineeship	7	481,091.00
	Centers of Excellence	2	8,148,777.00
	Faculty Development in Primary Care	1	112,687.00
	Geriatric Education Centers	1	423,968.00
	Health Careers Opportunity Program	3	2,004,969.00
	Minority Faculty Fellowships	1	53,313.00
	Model State-Supported Area Health Education Centers	1	165,176.00
	Nurse Anesthetist Traineeships	4	68,823.00
	Nurse Education Practice and Retention	2	627,557.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	230,518.00
	Other Health Professions Programs (Earmarks)	1	147,310.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	242,895.00
	Residency Training in Primary Care	3	781,175.00
	Scholarships for Disadvantaged Students	4	1,969,514.00
Totals for TN			$18,014,906.00
Texas	Academic Administrative Units in Primary Care	3	$545,729.00
	Advanced Education Nursing Grants	3	1,172,657.00
	Advanced Education Nursing Traineeship	16	1,031,130.00
	Allied Health Projects	1	167,824.00
	ASPH Cooperative Agreement	1	60,000.00
	Basic/Core Area Health Education Centers	1	807,596.00
	Bioterrorism Training and Curriculum Development Program	1	1,500,000.00
	Center for Health Workforce	1	250,000.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Centers of Excellence	5	4,194,324.00
	Comprehensive Geriatric Education Program	2	362,914.00
	Dental Public Health Residency Training Grants	1	101,292.00
	Faculty Development in Primary Care	3	1,200,020.00
	Geriatric Education Centers	3	860,762.00
	Geriatric Training Program for Physicians, Dentists, and Behavioral and Mental Health Professions.	1	650,544.00
	Graduate Psychology Education Programs	1	213,515.00
	Grants to States for Loan Repayment	1	213,600.00
	Health Administration Traineeships and Special Projects	4	188,823.00
	Health Careers Opportunity Program	3	1,104,719.000
	Health Education and Training Centers	1	456,671.0
	Model State-Supported Area Health Education Centers	2	1,156,218.00
	NRSA for Primary Medical Care	1	462,116.00
	Nurse Anesthetist Traineeships	2	103,766.00
	Nurse Education Practice and Retention	5	1,611,725.00
	Nurse Education Practice and Retention: Career Ladder	4	904,986.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	4	942,720.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	2	312,250.00
	Nursing Workforce Diversity	6	1,605,710.00
	Other Health Professions Programs (Earmarks)	2	294,621.00
	Physician Assistant Training in Primary Care	4	643,693.00
	Podiatric Residency Training in Primary Care	1	280,314.00
	Pre-Doctoral Training in Primary Care	4	635,732.00
	Public Health Traineeship	3	94,545.00
	Public Health Training Centers	1	313,213.00
	Residency Training in Primary Care	5	1,251,632.00
	Scholarships for Disadvantaged Students	12	2,446,879.00
Totals for TX			$28,145,240.00
US Virgin Islands	Health Careers Opportunity Program	1	$314,347.00
	Nursing Workforce Diversity	1	186,657.00
	Scholarships for Disadvantaged Students	1	72,874.00
Totals for VI			$573,878.00
Utah	Academic Administrative Units in Primary Care	1	$247,320.00
	Advanced Education Nursing Grants	1	264,483.00
	Advanced Education Nursing Traineeship	1	111,413.00
	Comprehensive Geriatric Education Program	1	152,065.00
	Faculty Development in Primary Care	1	415,995.00
	Grants to States for Loan Repayment	1	5,000.00
	Health Careers Opportunity Program	1	276,374.00
	Model State-Supported Area Health Education Centers	1	247,761.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	194,047.00
	Nursing Workforce Diversity	1	267,904.00
	Physician Assistant Training in Primary Care	1	162,379.00
	Pre-Doctoral Training in Primary Care	1	119,988.00
Totals for UT			$2,464,729.00
Vermont	Academic Administrative Units in Primary Care	1	$199,800.00
	Advanced Education Nursing Traineeship	1	13,475.00
	Model State-Supported Area Health Education Centers	1	247,761.00
	Nurse Education Practice and Retention: Career Ladder	1	202,790.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	77,601.00
	Nurse Education, Practice and Retention: Internship and Residency Program.	1	219,812.00
	Pre-Doctoral Training in Primary Care	1	111,255.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
	Residency Training in Primary Care	1	149,938.00
Totals for VT			$1,222,432.00
Virginia	Academic Administrative Units in Primary Care	2	$468,062.00
	Advanced Education Nursing Grants	5	2,330,788.00
	Advanced Education Nursing Traineeship	9	522,847.00
	Allied Health Projects	1	146,900.00
	Comprehensive Geriatric Education Program	2	267,296.00
	Faculty Development in Primary Care	1	425,766.00
	Geriatric Education Centers	1	414,851.00
	Grants to States for Loan Repayment	1	60,624.00
	Health Administration Traineeships and Special Projects	1	55,229.00
	Health Careers Opportunity Program	1	343,718.00
	Model State-Supported Area Health Education Centers	1	660,696.00
	Nurse Anesthetist Traineeships	2	41,934.00
	Nurse Education Practice and Retention	2	638,856.00
	Nurse Education Practice and Retention: Career Ladder	3	619,151.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	138,780.00
	Physician Assistant Training in Primary Care	3	337,864.00
	Pre-Doctoral Training in Primary Care	3	541,827.00
	Residency Training in General and Pediatric Dentistry	1	251,937.00
	Residency Training in Primary Care	1	147,961.00
	Scholarships for Disadvantaged Students	4	737,836.00
Totals for VA			$9,230,683.00
Washington	Academic Administrative Units in Primary Care	1	$154,152.00
	Advanced Education Nursing Grants	1	1,927,303.00
	Advanced Education Nursing Traineeship	4	325,887.00
	Bioterrorism Training and Curriculum Development Program	1	197,473.00
	Center for Health Workforce	1	250,000.00
	Centers of Excellence	1	484,509.00
	Faculty Development in Primary Care	1	178,556.00
	Geriatric Education Centers	1	215,998.00
	Grants to States for Loan Repayment	2	290,330.00
	Health Administration Traineeships and Special Projects	1	14,286.00
	Health Careers Opportunity Program	2	835,839.00
	Health Education and Training Centers	1	300,087.00
	Model State-Supported Area Health Education Centers	1	495,522.00
	NRSA for Primary Medical Care	1	467,252.00
	Nurse Anesthetist Traineeships	1	3,015.00
	Nurse Education Practice and Retention	2	1,106,008.00
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	189,813.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	2	423,232.00
	Nursing Workforce Diversity	2	489,873.00
	Other Health Professions Programs (Earmarks)	1	294,619.00
	Pathways To Health Professions	1	43,824.00
	Physician Assistant Training in Primary Care	1	357,422.00
	Pre-Doctoral Training in Primary Care	1	170,439.00
	Public Health Traineeship	1	46,013.00
	Public Health Training Centers	1	433,353.00
	Quentin N. Burdick Program for Rural Interdisciplinary Training	1	312,429.00
	Residency Training in General and Pediatric Dentistry	2	432,492.00
	Residency Training in Primary Care	1	107,829.00
	Scholarships for Disadvantaged Students	3	288,495.00
Total for WA			$10,836,050.00

BHPr State by State Grant Report for Fiscal Year 2005—Continued

State	Program Name	# of Grants	Total # of Dollars
West Virginia	Academic Administrative Units in Primary Care	1	$218,803.00
	Advanced Education Nursing Traineeship	2	50,590.00
	Allied Health Projects	1	153,622.00
	Basic/Core Area Health Education Centers	1	972,532.00
	Geriatric Education Centers	1	431,997.00
	Grants to States for Loan Repayment	1	76,121.00
	Health Careers Opportunity Program	1	557,042.00
	Nurse Anesthetist Traineeships	1	15,382.00
	Nurse Education Practice and Retention: Career Ladder	2	453,714.00
	Pre-Doctoral Training in Primary Care	1	163,285.00
	Residency Training in Primary Care	1	313,000.00
	Scholarships for Disadvantaged Students	3	63,427.00
Totals for WV			$3,469,515.00
Wisconsin	Advanced Education Nursing Grants	2	$742,759.00
	Advanced Education Nursing Traineeship	8	349,691.00
	Comprehensive Geriatric Education Program	1	47,747.00
	Faculty Development in Primary Care	2	780,677.00
	Geriatric Education Centers	1	429,107.00
	Grants to States for Loan Repayment	1	149,602.00
	Health Careers Opportunity Program	1	1,008,872.00
	Health Education and Training Centers	1	326,615.00
	Model State-Supported Area Health Education Centers	1	330,615.00
	NRSA for Primary Medical Care	2	894,253.00
	Nurse Anesthetist Traineeships	1	6,984.00
	Nurse Education Practice and Retention: Career Ladder	1	-
	Nurse Education Practice and Retention: Enhancing Patient Care Delivery Systems.	1	171,817.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	298,743.00
	Nursing Workforce Diversity	2	499,573.00
	Other Health Professions Programs (Earmarks)	1	441,929.00
	Physician Assistant Training in Primary Care	2	375,731.00
	Pre-Doctoral Training in Primary Care	1	129,104.00
	Residency Training in General and Pediatric Dentistry	1	6,107.00
	Residency Training in Primary Care	2	290,626.00
	Scholarships for Disadvantaged Students	4	597,939.00
Totals for WI			7,878,224.00
Wyoming	Advanced Education Nursing Grants	1	$190,232.00
	Advanced Education Nursing Traineeship	1	42,503.00
	Faculty Development in Primary Care	1	113,514.00
	Nurse Education Practice and Retention: Career Ladder	1	188,646.00
	Nurse Education, Practice and Retention: Internship and Residency Programs.	1	104,691.00
Totals for WY			$639,586.00

HRSA/Bureau of Primary Health Care

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
Alabama	Community Health Center Program	$30,799,978	14
Alabama	Health Care for the Homeless	1,772,088	2
Alabama	Migrant Health Center and Migrant Health Programs	1,273,815	3
Alabama	Public Housing Primary Care	1,324,707	3
Alabama	Black Lung/Coal Miner Clinics Program	181,829	1

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
Alabama Total		$35,352,417	23
Alaska	Community Health Center Program	$23,685,612	24
Alaska	Health Care for the Homeless	904,779	2
Alaska Total		$24,590,391	26
American Samoa	Community Health Center Program	$493,210	1
American Samoa Total		$493,210	1
Arizona	Community Health Center Program	$26,419,514	13
Arizona	Health Care for the Homeless	3,115,376	2
Arizona	Migrant Health Center and Migrant Health Programs	1,939,524	3
Arizona	Healthy Communities Access Program	884,767	2
Arizona	Integrated Services Development Initiative	99,200	1
Arizona	Radiation Exposure Screening and Education Program	194,773	1
Arizona Total		$32,653,154	22
Arkansas	Community Health Center Program	$21,866,808	12
Arkansas	Health Care for the Homeless	263,126	1
Arkansas Total		$22,129,934	13
California	Community Health Center Program	$109,136,136	82
California	Health Care for the Homeless	23,018,935	24
California	Migrant Health Center and Migrant Health Programs	27,811,485	21
California	Public Housing Primary Care	3,337,576	7
California	Healthy Communities Access Program	9,239,206	13
California	Integrated Services Development Initiative	917,572	5
California Total		$173,460,910	152
Colorado	Community Health Center Program	$39,408,822	14
Colorado	Health Care for the Homeless	3,744,450	4
Colorado	Migrant Health Center and Migrant Health Programs	4,645,041	5
Colorado	Public Housing Primary Care	568,038	1
Colorado	Black Lung/Coal Miner Clinics Program	392,993	1
Colorado	Healthy Communities Access Program	1,820,371	2
Colorado	Integrated Services Development Initiative	350,766	2
Colorado	Radiation Exposure Screening and Education Program	282,368	1
Colorado Total		$51,212,849	30
Connecticut	Community Health Center Program	$14,693,205	10
Connecticut	Health Care for the Homeless	2,617,700	6
Connecticut	Public Housing Primary Care	630,643	2
Connecticut	Healthy Communities Access Program	2,654,337	4
Connecticut Total		$20,595,885	22
Delaware	Community Health Center Program	$3,486,614	3
Delaware	Health Care for the Homeless	265,682	1
Delaware	Migrant Health Center and Migrant Health Programs	529,133	1
Delaware Total		$4,281,429	5
District of Columbia	Community Health Center Program	$4,792,720	3
District of Columbia	Health Care for the Homeless	2,877,226	1
District of Columbia	Healthy Communities Access Program	474,347	1

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
District of Columbia Total		$8,144,293	5
Fed. States of Micronesia	Community Health Center Program	$190,943	1
Fed. States of Micronesia Total		$190,943	1
Florida	Community Health Center Program	$57,339,148	33
Florida	Health Care for the Homeless	6,772,688	8
Florida	Migrant Health Center and Migrant Health Programs	12,545,368	12
Florida	Emergency Supplement for Florida Hurricane Relief	1,287,918	5
Florida	Healthy Communities Access Program	6,118,649	7
Florida	Integrated Services Development Initiative	1,529,797	3
Florida Total		$85,593,568	68
Georgia	Community Health Center Program	$27,173,453	21
Georgia	Health Care for the Homeless	2,131,145	2
Georgia	Migrant Health Center and Migrant Health Programs	2,222,309	1
Georgia	Public Housing Primary Care	1,189,337	2
Georgia	Healthy Communities Access Program	2,883,106	4
Georgia Total		$35,599,350	30
Guam	Community Health Center Program	$987,461	1
Guam Total		$987,461	1
Hawaii	Community Health Center Program	$8,765,592	10
Hawaii	Health Care for the Homeless	488,678	1
Hawaii	Public Housing Primary Care	482,645	1
Hawaii	Native Hawaiian Health Care	12,738,145	8
Hawaii Total		$22,475,060	20
Idaho	Community Health Center Program	$10,701,827	9
Idaho	Health Care for the Homeless	617,453	1
Idaho	Migrant Health Center and Migrant Health Programs	4,009,208	7
Idaho	Healthy Communities Access Program	644,169	1
Idaho Total		$15,972,657	18
Illinois	Community Health Center Program	$58,333,162	31
Illinois	Health Care for the Homeless	4,810,089	3
Illinois	Migrant Health Center and Migrant Health Programs	1,997,454	3
Illinois	Public Housing Primary Care	1,704,311	3
Illinois	Black Lung/Coal Miner Clinics Program	973,531	2
Illinois	Healthy Communities Access Program	3,537,443	5
Illinois	Integrated Services Development Initiative	1,117,000	2
Illinois Total		$72,472,990	49
Indiana	Community Health Center Program	$12,765,336	13
Indiana	Health Care for the Homeless	1,556,938	3
Indiana	Migrant Health Center and Migrant Health Programs	870,011	1
Indiana	Public Housing Primary Care	415,555	1
Indiana	Integrated Services Development Initiative	119,040	1
Indiana Total		$15,726,880	19
Iowa	Community Health Center Program	$11,409,883	8
Iowa	Health Care for the Homeless	902,648	3
Iowa	Migrant Health Center and Migrant Health Programs	398,620	1

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
Iowa	Integrated Services Development Initiative	106,640	1
Iowa Total		$12,817,791	13
Kansas	Community Health Center Program	$5,780,911	8
Kansas	Health Care for the Homeless	521,859	1
Kansas	Migrant Health Center and Migrant Health Programs	658,498	1
Kansas	Healthy Communities Access Program	829,060	2
Kansas Total		$7,790,328	12
Kentucky	Community Health Center Program	$17,765,545	11
Kentucky	Health Care for the Homeless	2,420,468	4
Kentucky	Migrant Health Center and Migrant Health Programs	923,154	1
Kentucky	Black Lung/Coal Miner Clinics Program	776,034	2
Kentucky	Healthy Communities Access Program	975,841	1
Kentucky Total		$22,861,042	19
Louisiana	Community Health Center Program	$17,275,973	19
Louisiana	Health Care for the Homeless	1,719,774	2
Louisiana	Public Housing Primary Care	485,090	1
Louisiana	Healthy Communities Access Program	2,292,358	4
Louisiana	Integrated Services Development Initiative	124,000	1
Louisiana Total		$21,897,175	27
Maine	Community Health Center Program	$9,598,807	13
Maine	Health Care for the Homeless	723,656	2
Maine	Migrant Health Center and Migrant Health Programs	464,887	1
Maine	Public Housing Primary Care	155,000	1
Maine	Healthy Communities Access Program	1,553,369	2
Maine	Integrated Services Development Initiative	743,720	1
Maine Total		$13,239,439	20
Marshall Islands	Community Health Center Program	$483,977	1
Marshall Islands Total		$483,977	1
Maryland	Community Health Center Program	$17,710,043	12
Maryland	Health Care for the Homeless	1,625,446	1
Maryland	Migrant Health Center and Migrant Health Programs	421,528	3
Maryland	Healthy Communities Access Program	730,333	1
Maryland Total		$20,487,350	17
Massachusetts	Community Health Center Program	$36,878,460	28
Massachusetts	Health Care for the Homeless	4,144,181	5
Massachusetts	Migrant Health Center and Migrant Health Programs	399,512	1
Massachusetts	Public Housing Primary Care	992,839	2
Massachusetts	Healthy Communities Access Program	1,925,882	3
Massachusetts	Integrated Services Development Initiative	148,800	1
Massachusetts Total		$44,489,674	40
Michigan	Community Health Center Program	$30,192,857	22
Michigan	Health Care for the Homeless	3,010,124	7
Michigan	Migrant Health Center and Migrant Health Programs	5,122,167	4
Michigan	Healthy Communities Access Program	3,796,124	6
Michigan Total		$42,121,272	39

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
Minnesota	Community Health Center Program	$10,327,731	10
Minnesota	Health Care for the Homeless	2,059,487	2
Minnesota	Migrant Health Center and Migrant Health Programs	1,954,526	1
Minnesota	Public Housing Primary Care	509,245	1
Minnesota	Healthy Communities Access Program	659,680	1
Minnesota	Integrated Services Development Initiative	404,736	2
Minnesota Total		$15,915,405	17
Mississippi	Community Health Center Program	$35,063,785	22
Mississippi	Health Care for the Homeless	515,319	2
Mississippi	Integrated Services Development Initiative	99,200	1
Mississippi Total		$35,678,304	25
Missouri	Community Health Center Program	$31,793,163	17
Missouri	Health Care for the Homeless	3,263,958	2
Missouri	Migrant Health Center and Migrant Health Programs	353,687	1
Missouri	Public Housing Primary Care	771,594	1
Missouri	Integrated Services Development Initiative	142,500	1
Missouri Total		$36,324,902	22
Montana	Community Health Center Program	$9,889,782	11
Montana	Health Care for the Homeless	1,538,295	1
Montana	Migrant Health Center and Migrant Health Programs	1,270,569	1
Montana	Healthy Communities Access Program	1,967,129	2
Montana Total		$14,665,775	15
Nebraska	Community Health Center Program	$3,907,730	5
Nebraska	Health Care for the Homeless	238,231	1
Nebraska	Migrant Health Center and Migrant Health Programs	501,299	1
Nebraska	Integrated Services Development Initiative	148,800	1
Nebraska Total		$4,796,060	8
Nevada	Community Health Center Program	$6,605,030	2
Nevada	Health Care for the Homeless	1,230,525	2
Nevada	Healthy Communities Access Program	745,395	1
Nevada	Radiation Exposure Screening and Education Program	220,000	1
Nevada Total		$8,800,950	6
New Hampshire	Community Health Center Program	$5,138,842	6
New Hampshire	Health Care for the Homeless	558,963	2
New Hampshire	Healthy Communities Access Program	566,127	1
New Hampshire	Integrated Services Development Initiative	237,894	1
New Hampshire Total		$6,501,826	10
New Jersey	Community Health Center Program	$24,371,832	14
New Jersey	Health Care for the Homeless	3,455,382	5
New Jersey	Migrant Health Center and Migrant Health Programs	626,023	2
New Jersey Total		$28,453,237	21
New Mexico	Community Health Center Program	$28,073,870	13
New Mexico	Health Care for the Homeless	2,387,301	2
New Mexico	Migrant Health Center and Migrant Health Programs	1,786,503	2
New Mexico	Black Lung/Coal Miner Clinics Program	270,936	1
New Mexico	Healthy Communities Access Program	1,473,622	2
New Mexico	Integrated Services Development Initiative	297,600	1

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
New Mexico	Radiation Exposure Screening and Education Program	429,919	2
New Mexico Total		$34,719,751	23
New York	Community Health Center Program	$78,643,560	41
New York	Health Care for the Homeless	10,281,355	13
New York	Migrant Health Center and Migrant Health Programs	3,540,750	3
New York	Public Housing Primary Care	1,519,924	3
New York	Healthy Communities Access Program	5,852,369	7
New York Total		$99,837,958	67
North Carolina	Community Health Center Program	$29,233,947	23
North Carolina	Health Care for the Homeless	748,825	3
North Carolina	Migrant Health Center and Migrant Health Programs	9,313,282	7
North Carolina	Healthy Communities Access Program	2,873,976	4
North Carolina	Integrated Services Development Initiative	633,312	1
North Carolina Total		$42,803,342	38
North Dakota	Community Health Center Program	$2,678,976	4
North Dakota	Health Care for the Homeless	321,223	1
North Dakota	Healthy Communities Access Program	576,894	1
North Dakota Total		$3,577,093	6
Ohio	Community Health Center Program	$33,043,646	21
Ohio	Health Care for the Homeless	4,867,471	6
Ohio	Migrant Health Center and Migrant Health Programs	829,458	1
Ohio	Public Housing Primary Care	1,223,539	2
Ohio	Black Lung/Coal Miner Clinics Program	548,379	1
Ohio	Healthy Communities Access Program	1,307,407	2
Ohio	Integrated Services Development Initiative	297,600	1
Ohio Total		$42,117,500	34
Oklahoma	Community Health Center Program	$10,154,954	11
Oklahoma	Health Care for the Homeless	783,350	2
Oklahoma	Migrant Health Center and Migrant Health Programs	318,203	1
Oklahoma	Healthy Communities Access Program	348,625	1
Oklahoma	Integrated Services Development Initiative	152,421	1
Oklahoma Total		$11,757,553	16
Oregon	Community Health Center Program	$23,337,092	19
Oregon	Health Care for the Homeless	3,804,369	7
Oregon	Migrant Health Center and Migrant Health Programs	4,058,672	7
Oregon	Healthy Communities Access Program	1,746,939	3
Oregon	Integrated Services Development Initiative	1,319,360	3
Oregon Total		$34,266,432	39
Palau	Community Health Center Program	$666,817	1
Palau Total		$666,817	1
Pennsylvania	Community Health Center Program	$37,783,431	26
Pennsylvania	Health Care for the Homeless	4,903,898	4
Pennsylvania	Migrant Health Center and Migrant Health Programs	1,291,792	1
Pennsylvania	Public Housing Primary Care	2,730,328	4
Pennsylvania	Black Lung/Coal Miner Clinics Program	619,716	3
Pennsylvania	Healthy Communities Access Program	2,082,259	3

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
Pennsylvania	Integrated Services Development Initiative	280,821	2
Pennsylvania Total		$49,692,245	43
Puerto Rico	Community Health Center Program	$32,039,892	19
Puerto Rico	Health Care for the Homeless	795,701	2
Puerto Rico	Migrant Health Center and Migrant Health Programs	7,264,377	6
Puerto Rico Total		$40,099,970	27
Rhode Island	Community Health Center Program	$9,442,810	6
Rhode Island	Health Care for the Homeless	694,426	2
Rhode Island Total		$10,137,236	8
South Carolina	Community Health Center Program	$34,667,145	19
South Carolina	Health Care for the Homeless	1,624,365	4
South Carolina	Migrant Health Center and Migrant Health Programs	1,400,750	4
South Carolina	Public Housing Primary Care	396,628	1
South Carolina	Healthy Communities Access Program	2,727,337	4
South Carolina Total		$40,816,225	32
South Dakota	Community Health Center Program	$6,898,656	7
South Dakota	Health Care for the Homeless	160,024	1
South Dakota	Integrated Services Development Initiative	148,800	1
South Dakota Total		$7,207,480	9
Tennessee	Community Health Center Program	$25,513,579	21
Tennessee	Health Care for the Homeless	2,016,153	4
Tennessee	Migrant Health Center and Migrant Health Programs	772,735	3
Tennessee	Black Lung/Coal Miner Clinics Program	159,781	1
Tennessee	Healthy Communities Access Program	2,188,230	3
Tennessee Total		$30,650,478	32
Texas	Community Health Center Program	$75,161,952	47
Texas	Health Care for the Homeless	6,804,614	8
Texas	Migrant Health Center and Migrant Health Programs	7,079,143	12
Texas	Public Housing Primary Care	920,248	2
Texas	Healthy Communities Access Program	4,831,103	6
Texas	Integrated Services Development Initiative	148,741	1
Texas Total		$94,945,801	76
U.S. Virgin Islands	Healthy Communities Access Program	$629,875	1
U.S. Virgin Islands Total		$629,875	1
Utah	Community Health Center Program	$8,902,972	10
Utah	Health Care for the Homeless	982,901	1
Utah	Migrant Health Center and Migrant Health Programs	483,178	1
Utah	Healthy Communities Access Program	278,320	1
Utah	Integrated Services Development Initiative	272,800	1
Utah	Radiation Exposure Screening and Education Program	495,935	2
Utah Total		$11,416,106	16
Vermont	Community Health Center Program	$3,042,555	3
Vermont	Health Care for the Homeless	434,479	1

HRSA/Bureau of Primary Health Care—Continued

Grant Programs Totals by State for Fiscal Year 2005*

State	Program Name	Financial Assistance	Number of Grants
Vermont Total		$3,477,034	4
Virgin Islands	Community Health Center Program	$1,519,153	2
Virgin Islands Total		$1,519,153	2
Virginia	Community Health Center Program	$24,779,135	20
Virginia	Health Care for the Homeless	1,225,902	2
Virginia	Migrant Health Center and Migrant Health Programs	1,486,616	2
Virginia	Black Lung/Coal Miner Clinics Program	470,991	1
Virginia	Healthy Communities Access Program	1,849,742	4
Virginia	Integrated Services Development Initiative	386,797	2
Virginia Total		$30,199,183	31
Washington	Community Health Center Program	$30,466,772	20
Washington	Health Care for the Homeless	4,464,526	6
Washington	Migrant Health Center and Migrant Health Programs	9,904,257	7
Washington	Public Housing Primary Care	148,876	1
Washington	Healthy Communities Access Program	1,519,455	3
Washington Total		$46,503,886	37
West Virginia	Community Health Center Program	$22,846,454	27
West Virginia	Health Care for the Homeless	387,006	1
West Virginia	Migrant Health Center and Migrant Health Prorams	761,767	1
West Virginia	Black Lung/Coal Miner Clinics Program	1,245,591	1
West Virginia	Healthy Communities Access Program	583,315	1
West Virginia	Integrated Services Development Initiative	892,800	2
West Virginia Total		$26,716,933	33
Wisconsin	Community Health Center Program	$12,693,589	13
Wisconsin	Health Care for the Homeless	1,889,961	3
Wisconsin	Migrant Health Center and Migrant Health Programs	713,793	1
Wisconsin Total		$15,297,343	17
Wyoming	Community Health Center Program	$2,329,730	2
Wyoming	Health Care for the Homeless	708,473	2
Wyoming	Migrant Health Center and Migrant Health Programs	215,036	1
Wyoming	Black Lung/Coal Miner Clinics Program	250,326	1
Wyoming Total		$3,503,565	6

Prepared on March 16, 2006.

HRSA/Bureau of Primary Health Care

Grant Programs Totals by State for Fiscal Year 2005*

	Number of Grants	Financial Assistance
Community Health Center Program	879	1,259,154,579
Health Care for the Homeless	178	133,170,992
Migrant Health Center and Migrant Health Programs	135	122,158,130
Public Housing Primary Care	39	19,506,123
Black Lung/Coal Miner Clinics Program	15	5,890,107
Emergency Supplement for Florida Hurricane Relief	5	1,287,918
Healthy Communities Access Program	109	75,167,161
Integrated Services Development Initiative	40	11,120,717
Radiation Exposure Screening and Education Program	7	1,622,995

Prepared on March 16, 2006.

Question 2. Ms. Duke, in your testimony, you refer to the importance of "to serving the neediest first" by developing a new medical index of severity that would drive funding. Every State and EMA is capable of demonstrating significant unmet needs in each area, but they suffer shortfalls in Federal support for medications under Part D of Medicare; primary care under Medicaid and other support services. Do you interpret serving the neediest first to mean the "neediest individuals" nationwide, or do you mean the "neediest jurisdictions, because they are not the same?"

Answer 2. In the case of health, health comes down to individuals. Our goal is to distribute CARE Act dollars equitably so that funding is available to serve individuals living with HIV/AIDS who cannot afford to pay for the care they need.

Question 3. In assessing a jurisdiction's "need" for funding, you also reference taking into account other existing resources. Would you agree that it is short-cited to consider the resources that State and locals have committed to supplement the CARE Act, for example through a strong Medicaid program, in accessing the need for Ryan White funds? Many States have made a huge commitment to the health care of their poor and disabled citizens. Do you think it is fair to use that investment against them in allocating funding under Ryan White?

Answer 3. The President's principles call for more equitable distribution of CARE Act funds. Important existing provisions in the legislation, such as maintenance of effort and the matching fund requirement, will continue to safeguard against the diversion or reduction of State and local funds away from critical HIV/AIDS services. We will continue to be vigilant to ensure that new CARE Act dollars will not be used to supplant State and local efforts.

Question 4. What are the current mechanisms for estimating relative unmet need within and across jurisdictions? What points of evidence are relied on to make these estimates? And has the contribution of all four titles been included in those estimates?

Answer 4. With the reauthorization of the CARE Act in 2000 HRSA/HAB has worked with our grantees and expert consultants to develop a methodology for estimating unmet need within their jurisdictions. Unmet need is defined as those who "know their HIV status and are not receiving HIV-related services." Since fiscal year 2004, all title I and II grantees have been using this methodology to determine unmet need within their jurisdictions. The jurisdictions have been gathering data from many sources including Medicaid, Veterans Affairs hospitals, State prisons, and other providers of HIV care within their areas.

Moreover, with the assistance of the consultants, HAB has reviewed all the grantee submissions and as a result, focused specific technical assistance to those grantees who continue to experience difficulty in using the methodology. Nevertheless, HAB believes that all grantees will be able to identify individuals meeting the unmet need definition within fiscal year 2006. With this information grantees will be better able to target their resources to those most in need within their jurisdictions. In determining unmet need, States have worked with other service providers including those funded under title III and IV to derive unmet need estimates.

Question 5. Massachusetts currently uses a code-based system to identify HIV cases. They have had good feedback from CDC on the validity and reliability of this code-based system. In the 2000 reauthorization of Ryan White, it was mandated that by 2004 the Secretary begin to collect "accurate and reliable HIV data" AND

in deciding what is "accurate and reliable," consideration should be given to the IOM study that was commissioned. The IOM study clearly states that both name-based and code-based would be equally acceptable if it was reliable. Why is the CDC demanding Massachusetts to collect names when it has never been established that their code-based system didn't work?

Answer 5. CDC must collect HIV data in all States using the same standard, scientifically accurate and reliable system of patient identification that enables removal of duplicate cases across States (interstate de-duplication) to give an accurate national picture of the HIV epidemic. CDC's policy is to report HIV infection and AIDS cases surveillance data only from areas conducting confidential name-based reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. HIV case surveillance that is conducted using coded patient identifiers has not been shown to routinely produce equally accurate, timely, or complete data compared to that conducted using confidential, name-based surveillance methods.

CDC conducted a nationwide evaluation of interstate duplication that demonstrated substantial numbers of HIV cases in many States were actually repeat reports of individuals who had been previously diagnosed and reported in other States. This evaluation highlighted the need to establish a single, standard, and accurate patient identifier across all States to ensure that duplicate reports can be identified and eliminated from the national database. Based on the need for a scientifically reliable and accurate system of national HIV reporting, CDC recommended in July 2005 that all States implement name-based HIV surveillance.

Because the legal authority for disease reporting resides with State and local health departments CDC continues to provide funding and technical assistance to States that use alternative methods for identifying patients in their HIV surveillance system. However, data from States using such alternative methods cannot be integrated into the national data system because there is no equitable, systematic or scientifically verified method of patient identification that can be used to remove duplicate reports across States regarding the same individual. CDC does not receive the names of individuals but identifies records from different States that have enough similarities to suggest that they may represent the same person. CDC sends the States information about these records, and the States then communicate directly with each other, using the patient name as the identifier, to identify duplicate reports across the States.

Name-based public health surveillance has been the standard method used to identify individuals in population-based disease reporting systems since these programs were instituted in the United States during the beginning of the 20th century. All other reportable infectious and non-infectious disease surveillance systems use name as the patient identifier. These surveillance systems have a long history of providing accurate information that is critical for guiding public health programs while protecting patient confidentiality and privacy at the local, State and Federal level. When surveillance data are sent to CDC for developing a national disease registry, personal identifiers are maintained at the State or local level and not sent to CDC. AIDS surveillance has been conducted using the standard name-based surveillance approach since the early 1980s.

Currently, 43 States use confidential name-based HIV case reporting. The remaining seven States and the District of Columbia use code or name-to-code reporting. Among those nine areas, there are eight different codes. Several of these States have notified CDC that they intend to implement name-based HIV surveillance in 2006.

Clarification to Response From Betty Duke

At the time of Dr. Duke's statement at the Senate HELP Committee hearing, nine States and the District of Columbia continued to use code-based or name-to-code systems.

Transcript

DUKE: My understanding—and I am not at CDC—but my understanding is that the interpretation of the law as it exists is that CDC must certify that the systems meet the standards of the law and that they have said that they can't certify code-based or name code-based systems. And we have about 13 or 14 States who have some situations. And I believe my colleagues at CDC can work with you on that—where they are having problems with compliance with what they view is the intent of the law.

Question 6. How does the Administration plan to direct future RWCA allocations to States that have recently adopted name-based HIV surveillance systems and States that have immature HIV surveillance systems, where the CDC does not cer-

tify their HIV case reports? Does the Administration plan to estimate living HIV/AIDS cases in these States until such time that these cases are certified?

Answer 6. In accordance with requirements in the CARE Act Amendments of 2000, to ensure that HIV case data are available from all States no later than fiscal year 2007, CDC continues to provide technical assistance to States to facilitate their change to name-based HIV surveillance systems.

Question 7. What is the Administration's intent with regard to the current title structure of the Care Act? If changes are proposed, what is the true evidence that an altered title I/II structure would more effectively address unmet need across the country?

Answer 7. The Administration, after much deliberation, has determined that the title structure of the Ryan White CARE Act should remain. The findings of both IOM and GAO are conclusive: without altering several legislative provisions that create structural barriers under titles I and II in the CARE Act, funding per AIDS case will continue to vary greatly. Because of the current structural barriers, the CARE Act will be unable to distribute funds equitably and effectively address unmet need across the country.

Question 8. Eligible Metropolitan Areas have drawn in and provided services to many patients that live outside of these metropolitan areas. Over time, these cities have developed critical infrastructure that serve as models of comprehensive care that we aspire to provide to all people living with HIV/AIDS. Changes in the title I and title II structure could drastically reduce funding to these Metropolitan areas, dismantling some of the centers of excellence for HIV/AIDS care that we hold up as models. Would you agree that it would be counterproductive to reduce critical funding to cities that not only provide superior services, but also draw in patients from surrounding areas where such a comprehensive infrastructure is neither available nor likely feasible in the future?

Answer 8. The President's principles call for more equitable distribution of CARE Act funds, which is paramount in the reauthorization. Proposed changes in the CARE Act are not intended to destabilize services, but are designed to assure that persons in need of HIV services and unable to pay for them shall be able to receive those services. By maintaining important provisions in current law, such as maintenance of effort and matching fund requirements, the Administration will ensure that States continue to contribute State and local funds to critical HIV/AIDS services.

Question 9. The Administration's conception of prevention focuses solely on testing. It is listed as one of the Administration's Ryan White CARE Act Reauthorization principles and approximately half of the new funding for HIV/AIDS in the fiscal year 2007 President's Budget goes to increased HIV testing. Although HIV testing is an important intervention to help bring infected individuals into care, a testing-only strategy neglects essential primary behavior change interventions that can protect at-risk groups by educating and empowering them to reduce or avoid the risk of becoming infected in the first place. Wouldn't you agree that the Administration should invest also in broad-based HIV prevention strategies?

Answer 9. To have the largest impact on the HIV epidemic, CDC utilizes a comprehensive approach to HIV prevention. HIV testing is only one part of CDC's three-pronged approach to HIV prevention. The three elements of this approach are: (1) HIV counseling, testing, and referral services; (2) HIV prevention with persons who are at high risk of acquiring HIV; and (3) HIV prevention with persons living with HIV.

Comprehensive HIV prevention is a broad term that incorporates surveillance, research, prevention interventions and evaluation. CDC's surveillance and research activities help to better define and understand the HIV/AIDS epidemic across the Nation. CDC's prevention interventions and capacity building efforts are based on behavioral, laboratory and medical science and work to contain the spread of HIV and AIDS. Program evaluation and policy research and development assess intervention effectiveness and refine prevention approaches. Additional information about CDC's comprehensive approach to HIV prevention is contained in the attached fact sheet, "Comprehensive HIV Prevention."

In Fiscal Year 2006, CDC received $651.1 million for domestic HIV/AIDS prevention activities conducted by the National Center for HIV, STD, and TB Prevention. It is estimated that 14 percent of this total will be spent on surveillance activities; 9 percent on prevention research; 9 percent on capacity building/technical assistance efforts; 63 percent on intervention activities including testing programs and other prevention activities carried out by State, local and community-based organizations (CBOs); and 5 percent on program evaluation and policy development. An additional

$68.6 million will be spent CDC-wide on efforts such as HIV school health education, safe motherhood, hemophilia programs, and preventing nosocomial transmission. The vast majority of CDC's domestic HIV/AIDS funding is spent extramurally through cooperative agreements to private-sector, State and local health departments, education agencies, non-governmental organizations, and CBOs.

For fiscal year 2007, we have proposed expanding our HIV testing efforts. HIV testing is an integral part of CDC's HIV prevention strategy, as knowledge of one's HIV infection can help prevent spread of the infection to others. Studies have shown that when people know that they are infected with HIV, they are significantly more likely to protect their partners from infection than when they were unaware of their infection. We think that this initiative will identify a large number of previously undiagnosed cases, and help those persons link to care, treatment and counseling, and avoid transmitting HIV to others.

QUESTIONS OF SENATOR BURR

Question 1. The President has proposed ". . . to make $70 million available to States in need to bridge the existing gaps in coverage for Americans waiting for life-saving medications. These funds would help the States end current waiting lists and help support care for additional patients."

Will this new $70 million resource be more appropriately targeted than the Special Presidential ADAP Initiative so that States with ADAP Programs in "severe need"—not just indicated by a single factor at a particular point in time but based on a variety of limitations and constraints over time—will have access to a portion of this funding on a more comprehensive and reasonable basis?

Answer 1. The $70 million will be used to help the States end current ADAP waiting lists and help support care for additional patients. The funding mechanism is under discussion within the Department.

Question 2. Could you explain why when you combine the money that is going to each State—title I and II funding—a State like California receives $5,264 per AIDS case, while North Carolina receives $3,727, Mississippi receives $3,442 per case and Iowa just $3,340? [Source: GAO Testimony, June 23, 2005]

Answer 2. Grantees do not receive the same level of title I and title II funding per person living with AIDS because of various formula provisions that impact the proportional allocation of funding. Below are three reasons for this variation as stated in the "HIV/AIDS: Changes Needed to Improve the Distribution of Ryan White CARE Act and Housing Funds" (GAO-06-332):

• *Using AIDS Cases in Formulas*—The CARE Act uses measures of AIDS cases that do not accurately reflect the number of persons living with AIDS. Title I and Title II CARE Act funding is based on case counts that could include deceased cases because the eligibility and allocation are determined using cumulative case counts. Additionally, the CARE Act's use of estimated living cases (ELCs), which are determined using the most recent 10 years of reported AIDS cases, to distribute the majority of formula funding does not take into account that many AIDS patients now live longer than 10 years after their disease is reported. HRSA has indicated that the GAO language above regarding using AIDS cases in formulas omits a very important factor: The 10-year band of AIDS cases is adjusted by a survival rate factor that compensates for the so called "deceased cases" in the 10-year period. The survival rate factor is calculated for each year of the 10 years and is prepared by CDC to address the issue of those who have died.

• *Double Counting*—Some CARE Act Title I and Title II provisions related to metropolitan areas result in variability in the amount of funding per ELC among grantees. For instance, the counting of ELCs within the EMAs once for determining title I base grants and once again for determining title II base grants results in States with EMAs and Puerto Rico receiving more total title I and title II funding per ELC than States with no EMA or with comparatively few ELCs located in EMAs. Also, the division of Title II Emerging Communities into two tiers based on their number of reported AIDS cases in the past 5 years leads to funding differences among grantees.

Hold Harmless Provision—The CARE Act hold harmless provisions under title I and title II and the grandfather clause for EMAs under title I makes the funding of certain grantees protected. For example, the CARE Act Title I hold harmless provision results in San Francisco EMA's funding being based in part on the number of deceased cases in the EMA in 1995. In addition, the title II hold harmless provision, which has had little impact thus far, has the potential to reduce the amount of funding to grantees for severe need of drug treatment funds because the hold harmless grantees are funded from amounts set aside for ADAP Severe Need

grants. The Title I EMA grandfather clause protected the funding of more than one half of EMAs.

The President's principles for Reauthorization of the Ryan White CARE Act, released July 27, 2005, address these three key issues impacting the proportional allocation of title I and title II funding. The principles would make the program more responsive by:

• *Using HIV Cases in Formula*—Maintain the current statutory requirement that all States submit HIV data by the start of fiscal year 2007. Having the full scope of HIV is critical to successful care and treatment programs that prevent people from advancing to AIDS.

• *Eliminating Double Counting*—Eliminating the double counting of HIV/AIDS cases between major metropolitan areas (title I) and the States (title II).

• *Eliminating Hold Harmless Provision*—Eliminating current provisions that entitle cities to be "held harmless" in funding reductions.

Quesiton 3. Does this discrepancy in funding have anything to do with a State's Medicaid generosity?

Answer 3. No, funding for title I is awarded as formula grants and supplemental grants in accordance with provisions in the CARE Act. Title II funding provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and eligible U.S. Pacific Territories based on the number of reported AIDS cases. Title II also provides funding for the AIDS Drug Assistance Program (ADAP).

To be eligible for a Title I Grant for Eligible Metropolitan Areas (EMAs), an area must have reported at least 2,000 AIDS cases during the previous 5 years and have a population of at least 500,000. Title I funding to EMAs includes formula and supplemental components. Formula grants are based on the estimated number of living cases of AIDS over the most recent 10-year period. Supplemental grants are awarded competitively based on demonstration of severe need and other criteria.

Title II of the Ryan White CARE Act provides grants to all 50 States, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, and five newly eligible U.S. Pacific Territories and Associated Jurisdictions. Title II also funds the AIDS Drug Assistance Program (ADAP) and grants to States for Emerging Communities—areas reporting between 500 and 1,999 AIDS cases over the most recent 5 years. Base title II grants are awarded to States and Territories using a formula that is based on reported AIDS cases. Additional title II funds are "earmarked" for State AIDS Drug Assistance Programs (ADAPs), which primarily provide medications. Fundable services also include treatment adherence and support, as well as health insurance coverage with prescription drug benefits. Three percent of the ADAP earmark is reserved for grants to States and Territories with severe need for medication assistance.

Question 4. So it seems that the States with an EMA receive more money per case. What is double counting and do some States benefit from that as well? How do you suggest the Congress address the double counting issue?

Answer 4. The most recent 10 years of Estimated Living AIDS Cases (ELCs) are calculated for all States and territories. Eighty percent of the title II base award is based upon each State's proportion of the total ELCs in all States and territories. The remaining 20 percent is based upon each State's proportion of the total ELCs in all States and territories that are located outside the Eligible Metropolitan Areas (EMAs) within a State. This is to give States without EMAs an extra boost and was enacted under the 1996 reauthorization law. However, this does result in the double counting; in effect, a portion, but not all of the cases attributed to an EMA in a State are counted twice in calculating the title II base award. Eliminating the "double counting" phenomenon would mean that the State's base award, in a State with EMA(s), would be based solely on the ELCs in the non-EMA area of the State.

For example, the total number of estimated cases in Colorado is 2,477 with 1,830 living within the EMA, and 647 living outside the EMA. Currently Colorado's award is based on 80 percent of the proportion in the State and 20 percent on the proportion outside the EMA. Additionally, the EMA receives title I funds based on the cases within the EMA. If we should eliminate the 80–20 provision of 1996, Colorado's base award would be based on the 647 cases living outside the EMA, with the EMA receiving funding for the cases within the EMA.

The Administration's principles propose to eliminate double counting of AIDS cases between EMAs and States.

Question 5. Included in the discussions of trying to bring greater equity to the distribution of funds within the Ryan White CARE Act is the concept of "eliminating double counting." If eliminating double counting results only in redistributing title II funds according to AIDS cases outside of the Eligible Metropolitan Areas (EMAs),

which is the way it appears in the Administration's principles and proposals, then some of the States with title I cities/EMAs will lose a significant amount of funding and be extremely disadvantaged. The only approach that will result in greater reasonableness and equity in the distribution of Ryan White CARE Act funds is combining the funding that is available through both title I and title II into one single "care" resource, and then distributing that total amount on a "per capita" (e.g., $/reported case of AIDS) basis.

Could the Administration be supportive of combining the title I and title II funding into one single "care" resource?

Answer 5. Central to the issue of equitable distribution of CARE Act funds is the issue of formula-driven provisions in the CARE Act. The Administration's reauthorization principles speak directly to this issue. Combining title I and II funding would not solve the equity issue. We believe that having core medical services under title I and minimum drug lists under title II more directly addresses the issue of equitable care than would combining titles I and II.

Question 6. The Administration's reauthorization principles call for better coordination of State and local delivery of services. Could you explain what the problem is today and how you envision it to be improved?

Answer 6. A coordinated effort between the States, cities, and other CARE providers is essential to effective, comprehensive care and prevention services. Currently, health care programs have a history of operating separately from each other, and some may not be accustomed to cooperating in the provision of services to clients. In some cases, this could be because program staff is uninformed about how to pursue the program linkages that are possible. Provider agencies also indicate that varying reporting requirements and the distribution of funding for similar services across several programs place limits on the time available for service coordination for clients.

In order to improve the coordination of services, the Department would establish and maintain relationships with State AIDS officials and provide to them all information necessary to coordinate care and treatment with other federally funded projects. Activities may include educating program staff on opportunities for coordination and integration, promoting and supporting participatory HIV service planning processes at the State and local levels, and State and local flexibility in managing resources and enforcing regulations. These and other efforts would yield important information about what is effective, what needs to be changed, how the future of HIV programs can be shaped to ensure the optimum use of Federal resources to provide the best possible care and services to people living with HIV disease, and will ultimately maximize the efficiency and effectiveness of AIDS services.

QUESTIONS OF SENATOR HATCH

Question 1. As one of the original authors of Ryan White, I want to be sure that the program will continue to be able to provide vital services to people living with HIV/AIDS. The epidemic has changed since the program's inception; and the legislation should adequately address those changes. I understand that defining the "core medical services" will play a major part in adjusting the legislation to make sure that the neediest patients are served first—can you tell me whose feedback will be included in determining those core services? More specifically, what will be the process to decide the core services index, the set of core medical services, and the list of core medications?

Answer 1. Various groups have developed lists of "core medical services" for people living with HIV and AIDS. In particular, the IOM study, "Public Financing and Delivery of HIV/AIDS Care," published in 2004, defined eight broad areas that capture the critical components of HIV care as listed below.

- Outpatient primary care medical services;
- Medications, including HAART;
- Other drug therapies for HIV-related comorbidities;
- Laboratory and radiological services;
- Oral health care;
- Obstetrics and reproductive health services for HIV-infected women;
- Outpatient mental health and substance abuse treatment and services;
- Home health and hospice care;
- Medical case management; and
- HIV prevention services.

Question 2. Given that core activities would be defined at the Federal level, what administrative burdens would be released from the State and local levels, including the requirements for evaluation, consortium and other related planning bodies?

Answer 2. The definition of core activities or services at the Federal level will still require CARE Act grantees to prioritize core service needs at the State, jurisdiction or local levels. As such, needs assessments for planning the prioritization and allocation of CARE Act funds will continue. It is anticipated, however, that more focused needs assessment, planning and priority setting processes will occur given the narrowing of the definition of eligible services under core activities.

Question 3. The structure of the Ryan White CARE Act has historically allowed for maximized State and local control. Services have long been made available through processes that assure prioritization of services based on needs assessment activities, epidemiological profiles and gap analysis processes. It seems reauthorization could limit this flexibility by saying that the Secretary, presumably through HRSA, will establish a set core of medical services and a set of core medications. If that happens, how will flexibility and local control be maintained?

Answer 3. While the President's principles indicate that 75 percent of grant funds should be used for core services, responsibility for planning and allocation of grant funds supporting both the core services and other non-core services will remain with those responsible for administering both the EMA and State grants. HAB will continue to hold these entities accountable for meeting their responsibilities in line with CARE Act requirements. Local control will remain along with flexibility within the statutory framework of the CARE Act.

Question 4. I have been working closely with the Utah Department of Health on this issue. To date, States have not received an adequate amount of funding to meet the present needs. Utah's ADAP program was closed recently for a 5-month period of time because of limited funding and program utilization growth. The President has recently called for increased HIV prevention and testing outreach. Although the President's budget includes an additional $93M for increased HIV testing among high-risk populations, there is obviously concern with any prevention activities which may reduce funding for care and treatment. What present requirements will be reduced or eliminated in order to make room for prevention activities through the title II programs, specifically?

Answer 4. The Administration's reauthorization principles propose creating stricter payer of last resort provisions that will ensure that CARE Act funds will be increasingly directed to fill gaps in service provisions for those persons who have no other source of payment for HIV/AIDS care and treatment. In addition, proposed provisions such as the implementation of routine voluntary HIV testing in public facilities and by private healthcare providers will be a key element in prevention efforts. Thus, the number of available providers of prevention services would increase, lessening the burden of prevention service provision on States. The proposals call for State and local care delivery coordination which would maximize efficiency and effectiveness of HIV/AIDS services between the State, local jurisdictions and community-based service providers, including key providers of HIV/AIDS prevention and outreach services.

Question 5. Do you feel that current eligibility requirements for Eligible Metropolitan Areas (EMAs) and Emerging Communities (ECs) appropriately address the epidemic? (If not, would changing those requirements and eliminating hold harmless provisions be a step in the right direction?)

Answer 5. The current eligibility requirements for EMAs, established in 1996, define an EMA having 2,000 AIDS cases in the most recent 5-year period and a population of at least 500,000. With the changing nature of the epidemic, spurred in large part by advances in treatment, the move to using HIV disease data will better represent the nature of the epidemic in areas. Lowering the threshold number of AIDS cases will increase the number of eligible EMAs, some of whom are currently Emerging Communities (EC) under title II. If the eligibility requirements for EMA designation were changed, there would be no need for an EC initiative under title II. Instead, EC dollars would be redirected to the State title II base grant. States would have the authority to plan for and deliver either directly or through consortia CARE Act services in those former EC areas.

QUESTIONS OF SENATOR DODD

Question 1. Title IV provides an important link to care, services and research for women, children, youth and families affected by HIV/AIDS. Title IV saves lives by providing treatment and care, improves quality of life by keeping people healthier, and saves money by reducing hospitalization.

Title IV projects have led the way in reducing mother-to-child transmission from more than 2,000 babies born HIV-positive each year to fewer than 200. In my home

State of Connecticut, a total of 213 babies have been born to HIV-positive mothers since 2002. Of that total only one baby has been confirmed as HIV-positive. But the battle against mother-to-child transmission is far from being won. As long as women of child-bearing age are living with HIV disease, we must stay focused on supporting and strengthening programs that outreach to HIV-infected pregnant women. Title IV programs bring HIV-infected pregnant women into care and help them adhere to their treatment regimens for the duration of their pregnancy and delivery. Following delivery, title IV nurses and case managers follow up to ensure the mother is administering the required 6-week treatment regimen to the newborn.

Given these successes, performed each and every day by title IV projects across the country, do you agree that the title IV model of care should be continued, strengthened and expanded in reauthorization?

Answer 1. The Administration's reauthorization principles did not propose to disassemble the title IV model. In addition, it is believed that by assuring the funding and availability of "core medical services," which will no doubt include prenatal and postnatal primary care treatment of HIV-infected women and their children, the title IV program would be strengthened.

Question 2. We have concerns that title IV would be severely damaged if funds were set aside for "core medical services," which are articulated in the President's principles as "basic, primary care and medication needs." There are two reasons for this. First, title IV is successful because it offers a broad range of family-centered services that are essential to getting mothers to take care of their own health, to keep children in care, to give mom the support she needs—like child care and transportation—to get her kids and herself to doctor appointments and the pharmacy, and to reaching out to HIV-infected youth and keeping them in care. Second, 80 percent of title IV's consumers have Medicaid, so for most patients, their doctor appointments and medications are already paid for by another source. What isn't necessarily paid for by other sources, and what is key to title IV, is the services that bring marginalized families struggling with HIV into medical care.

So, my question to you is what changes would the Administration like to see made to title IV? And, specifically, do you want Congress to apply a set-aside of title IV funds for "core medical services?"

Answer 2. Although the title IV program of the CARE Act is structured differently than the other titles, in essence the main goal is to assure that its clients receive core medical services, including primary medical care and medications. Because there is no final definition of core medical services as yet, it is difficult to predict which, if any, of the title IV funded services may face a possible reduction in funding. It is anticipated that many CARE Act programs may have to make modifications to their programs based on the application of the requirement to spend 75 percent of their funds on "core medical services." However, the change is designed to assure quality health care for HIV-infected individuals and uniformity of services for CARE Act clients across the country.

Question 3. We really need to do better by African-American women. The President spoke about this in his State of the Union address. Yet, the Administration's principles were virtually silent on the fact that 88 percent of people served by title IV are people of color.

What plans does HRSA have for making sure that the title IV family-centered care model, which has been a lifeline for women of color and their families since 1988, is able to serve more families of color?

Answer 3. The title IV program will continue to reach out to communities of color through its programs, as well as through the use of the Minority AIDS Initiative funding, to identify, enroll in services and retain in services women of color and their families. The program has utilized many unique approaches to outreach in communities of color, including through faith-based and community-based non-clinical programs that provide HIV prevention and education services and make referrals for counseling and testing. Utilizing these approaches reaches women in settings that are non-threatening and conducive to open and honest exchange of information about issues such as HIV.

Question 4. In the current law, CARE Act grantees may obtain a waiver permitting a lower proportion of their respective program funds to be set aside if the eligible metropolitan area or State can demonstrate that women, infant, children and youth are already receiving substantial HIV/AIDS primary care and related health services through one or more Federal and/or State funded programs. I am concerned that these waivers are too easy to obtain. Waivers should be subject to annual review, especially if case reporting does not shift to HIV status in 2007. A delay in

HIV data reporting would deny necessary services to women, infant, children, and youth.

How many title I and title II grantees have requested a waiver to treat women, infant, children and youth? What are the criteria HRSA uses to evaluate waiver requests?

Answer 4. Because CARE Act funded programs are the payer of last resort, women, infants, children or youth (WICY) living with HIV/AIDS in certain States and title I eligible metropolitan areas (EMAs) who qualify for Medicaid, the State Children's Health Program (SCHIP) or other eligible Federal or State funded programs, may have most of their HIV/AIDS primary care needs met through non-CARE Act resources. In such cases, CARE Act funds will pay for health and related support services not covered by the other programs such as nutritional services, case management, transportation, childcare and emergency assistance, which typically cost less than primary care. Thus, some EMAs and/or States may not need to use a proportionate share of their grant funds in order to address the HIV/AIDS care needs of one or more of these priority populations, which is why the Congress established a waiver provision.

To obtain a waiver for a particular priority population in any given fiscal year, an EMA or State must submit a request and document that the population is receiving HIV/AIDS health services through Medicaid, (SCHIP) or other eligible program expenditures. Documentation must be submitted within 120 days after the budget end date, and are carefully reviewed to insure that they comply with HRSA guidelines as follows:

1. Documented waiver expenditures must be clearly identified by source and qualify as eligible State or Federal expenditures.
2. Waiver expenditures must be for outpatient HIV/AIDS care only.
3. Expenditure data may NOT be aggregated, but rather must be documented separately for each priority population for which a waiver is requested.
4. As a general principle, expenditures to justify waiving the set-aside requirement should correspond to the fiscal year for which the waiver is being sought. At a minimum, documented expenditures must:

• Reflect an unbroken, continuous 12-month time period; and,

• Include at least 6 months worth of expenditures that correspond to the fiscal year for which the waiver is requested.

In addition, grantees requesting a waiver more than once must use consistent methods to document waiver-related expenditure data from 1 year to the next, and the documentation is subject to audit. Failure to document full compliance with HRSA's WICY waiver guidelines may result in grant funds being delayed for the next funding cycle until the grantee demonstrates that appropriate corrective actions are being taken to assure full compliance in the future.

A review of title I and II WICY related documentation for fiscal year 2004 (the most recent year for which such data has been submitted) was recently completed; the results are summarized below.

Title I: A review by HRSA found that all 51 (100 percent) EMAs provided documentation of required WICY spending and/or waiver-related expenditures for fiscal year 2004.

• 42 EMAs (82 percent) documented full compliance with the WICY requirement that met or exceeded their minimum spending levels for all priority populations. These are:

Atlanta (GA)	Jacksonville (FL)	Ponce (PR)
Austin (TX)	Kansas City (MS)	Portland (OR)
Baltimore (MD)	Los Angeles (CA)	Sacramento (CA)
Boston (MA)	Las Vegas (NV)	San Antonio (TX)
Caguas (PR)	Miami-Dade (FL)	San Bernardino (CA)
Chicago (IL)	Middlesex (NJ)	San Diego (CA)
Cleveland (OH)	Nassau/Suffolk (NY)	San Francisco (CA)
Denver (CO)	New Haven (CT)	San Jose (CA)
Detroit (MI)	Newark (NJ)	San Juan (PR)
Dutchess Co (NY)	Norfolk (VA)	Seattle (WA)
Fort Worth (TX)	Oakland (CA)	St. Louis (MO)
Hartford (CT)	Orlando (FL)	Tampa (FL)
Houston (TX)	Philadelphia (PA)	Vineland (NJ)

Jersey City (NJ)	Phoenix (AZ)	West Palm Beach (FL)

• 5 EMAs (10 percent) submitted required Waiver Documentation for one or more priority populations that complied fully with HRSA guidelines, and documented meeting their title I minimum spending requirement for any non-waived populations. These are:

Fort Lauderdale, FL: children New Orleans, LA: children Minneapolis, MN: all priority populations.	New York, NY: all priority populations. Washington, DC: all priority populations.

• 4 EMAs (8 percent) requested a waiver but HRSA has not approved it due to incomplete documentation of waiver expenditures. These are:

Bergen/Passaic, NJ: infants & children Dallas, TX: women	Orange County, CA: children Santa Rosa, CA: women

Title II: 51 (96 percent) of 53 title II grantees required to submit WICY Expenditure Reports and/or WICY Waiver Documentation for fiscal year 2004 (all 50 States, the District of Columbia, Puerto Rico, and the Virgin Islands) have done so. Please note: The territories of American Samoa, Federated States Micronesia, Guam, the Marshall Islands, Northern Marianas, and Republic of Palau are exempt because of the very small WICY population that they each serve. Below is a summary of HRSA's review of title II compliance with this requirement for that fiscal year.

• 26 grantees (49 percent) met or exceeded their minimum spending requirements in fiscal year 2004:

Alabama	Iowa	New Jersey	Utah
Arkansas	Kansas	Ohio	Virginia
California	Kentucky	Oregon	Washington
Colorado	Maryland	Pennsylvania	West Virginia
Connecticut	Michigan	Puerto Rico	Wisconsin
Hawaii	Nevada	Rhode Island	Wyoming
Indiana		Texas.	

• 16 grantees (30 percent) submitted required Waiver Documentation for one or more priority populations that complied fully with HRSA guidelines, and documented meeting their title I minimum spending requirement for any non-waived populations.

Arizona: children
District of Columbia: all populations
Florida: children
Illinois: all populations
Louisiana: children, youth
Maine: children, women
Massachusetts: all populations
Missouri: children
Nebraska: children
New Mexico: children, youth
New York: all populations
North Carolina: infants, children, youth

North Dakota: all populations
South Carolina: children
South Dakota: all populations
Vermont: children, youth

• 6 States (11 percent) did not satisfy their minimum spending level for one or more priority populations, and still need to request a waiver and/or provide required documentation.

Alaska: children
Delaware: children, women
Georgia: children
Idaho: children
Montana: children
Oklahoma: children

• 2 States (3.8 percent) did not satisfy their required minimum spending level for one or more priority populations and requested a waiver based on Medicaid spending. However, they have not yet obtained required documentation from their State Medicaid office for a 12-month period that includes at least 6 months that correspond to the title II fiscal year.

New Hampshire: children, youth	Tennessee: women

• 2 grantees (3.8 percent) required to submit WICY Expenditure Reports and/or Waiver Documentation for fiscal year 2004 have not done.

Question 5. Medicaid is the largest public payer of HIV/AIDS care in the United States. It accounts for more than half of Federal spending on HIV/AIDS and is a critical source of care for people living with HIV/AIDS. States have broad flexibility in determining Medicaid benefit packages that can limit the scope of services provided. For example, some States limit the number of prescriptions, hospital inpatient days, and physician visits allowed per month or year, while other States, such as Connecticut, have less restrictive services. In his principles for reauthorization, the President recommends that unspent funds from titles I and II be reverted to the Secretary of HHS for redistribution to States with the greatest need. This redistribution would result in substantial losses in funding for some States and gains in others. Those States with restrictive Medicaid packages would receive more Ryan White dollars than States with more comprehensive Medicaid packages.

So my question is how do you ensure that all people living with HIV/AIDS in the United States have access to comprehensive care and treatment without punishing States that have good entitlement programs?

Answer 5. The CARE Act was designed to build around the core of Medicaid services for people living with HIV/AIDS either by filling in the gaps in covered services for people who already had Medicaid or by providing services to individuals unable to afford them but were also ineligible for Medicaid. Medicaid is at the center of the care delivery system for people living with HIV/AIDS. CARE Act grantees recognize that services that are eligible under Medicaid and other third party payers must be billed first to those payers and that the CARE Act is the payer of last resort. In many States, CARE Act services have supplemented Medicaid services by providing support for additional medications where Medicaid has limits on the number of prescriptions per month per client. In other cases, CARE Act funds have supported ancillary or support services which the Medicaid program in that particular State does not cover. With reauthorization, CARE Act funds would continue to either supplement or complement Medicaid services within a State while maintaining its role as payer of last resort.

QUESTIONS OF SENATOR REED

HIV and Names Based Reporting

Background: Confidentiality is a crucial issue in medical care but of particular importance in the case of HIV. This bill is named for a child who suffered the stigma of HIV. Protecting confidentiality was a motivating factor for many States introducing code-based reporting systems. Under the 2000 CARE Act reauthorization, HIV case counts are required to be included in funding formulas no later then fiscal year 2007. States have been collecting HIV data, but some States have been doing so with a code-based system. Only in July of last year was my State's AIDS Director

first notified by CDC that it strongly recommended name-based counts and the agency only certifies name-based case counts. For States that report HIV by code or have recently changed to names systems and have incomplete HIV names data, a change in case reporting could result in drastic changes in funding that do not accurately account for the number of persons affected by HIV within the State. GAO's June 2005 testimony of Marcia Crosse, Factors that Impact HIV and Aids Funding and Client Coverage, notes "states that would benefit from the use of HIV cases tend to be those with the oldest HIV case reporting systems."

Question 1. What is the rationale for pushing States to names-based systems?

Answer 1. CDC must collect HIV data in all States using the same standard, scientifically accurate and reliable system of patient identification that enables removal of duplicate cases across States (interstate de-duplication) to give an accurate national picture of the HIV epidemic. CDC's policy is to report HIV infection and AIDS cases surveillance data only from areas conducting confidential name-based reporting because this reporting has been shown to routinely achieve high levels of accuracy and reliability. HIV case surveillance that is conducted using coded patient identifiers has not been shown to routinely produce equally accurate, timely, or complete data compared to that conducted using confidential, name-based surveillance methods.

CDC conducted a nationwide evaluation of interstate duplication that demonstrated substantial numbers of HIV cases in many States were actually repeat reports of individuals who had been previously diagnosed and reported in other States. This evaluation highlighted the need to establish a single, standard, and accurate patient identifier across all States to ensure that duplicate reports can be identified and eliminated from the national database. Based on the need for a scientifically reliable and accurate system of national HIV reporting, CDC recommended in July 2005 that all States implement name-based HIV surveillance.

Name-based public health surveillance has been the standard method used to identify individuals in population-based disease reporting systems since these programs were instituted in the United States during the beginning of the 20th century. All other reportable infectious and non-infectious disease surveillance systems use name as the patient identifier. These surveillance systems have a long history of providing accurate information that is critical for guiding public health programs while protecting patient confidentiality and privacy at the local, State and Federal level. When surveillance data are sent to CDC for developing a national disease registry, personal identifiers are maintained at the State or local level and not sent to CDC. AIDS surveillance has been conducted using the standard name-based surveillance approach since the early 1980s.

Currently, 43 States use confidential name-based HIV case reporting. The remaining seven States and the District of Columbia use code or name-to-code reporting. Among those nine areas, there are eight different codes. Several of these States have notified CDC that they intend to implement name-based HIV surveillance in 2006.

Question 2. For States that have not yet made the transition to a names-based system, what resources will be made available to them and how will CARE Act funding be calculated if the case data is not complete?

Answer 2. In accordance with requirements in the CARE Act Amendments of 2000, to ensure that HIV case data are available from all States no later than fiscal year 2007, CDC continues to provide technical assistance to States to facilitate their change to name-based HIV surveillance systems.

HIV and Medications

Background: As you know, access to medications for patients with HIV is becoming an increasing challenge. Many AIDS Drug Assistance Programs (ADAP) have waiting lists and many more are barely able to keep up with increasing demand. In addition, the recently passed Budget Reconciliation gives States the power—for the first time ever—to deny medications to Medicaid patients with HIV who are unable to pay cost sharing. In some cases, a person making $800 a month could be asked to pay $120 for a single bottle of HIV medications. The new Medicare Part D prescription drug benefit is not much of a benefit for many people with HIV either. As I am sure you are aware, the Part D plans contain what has come to be known as the "donut hole" between $2,250 and $5,100 in out of pocket costs. Given that the estimated average cost for 1 year of treatment for HIV is between $10,000 and $34,000, most persons with HIV medications will quickly reach the $2,250 threshold. However, many of the patients will be unable to afford the full cost of their medications during this lapse in coverage and may stop taking their medications.

It is my understanding that ADAP funds could be used to assist patients with drug costs during the "donut hole" but these subsidies would not count towards the $5,100 out-of-pocket spending limit because they are Federal dollars.

Question 3. Are States permitted to use ADAP funds to assist Medicaid and Medicare patients with co-pays and cost sharing requirements?

Answer 3. AIDS Drug Assistance Programs (ADAPs), in accordance with State program policy, can pay premiums, deductibles, co-insurance, and co-pays. ADAP can also help pay for the costs of the Medicare Part D prescription drug benefit. It is important to understand that ADAP contributions cannot be counted toward TrOOP requirements and, thus, ADAP contributions would delay someone reaching the catastrophic coverage level, particularly for partial low-income subsidy (LIS) and basic benefit individuals.

Question 3a. Can these expenditures be counted toward the $5,100 Part D catastrophic limit?

Answer 3a. No.

Question 4. What financial impact will this have on States?

Answer 4. States will continue to support clients who are eligible for Medicare Part D up to their TrOOP requirement. At this point, State ADAP will cover the full costs of HIV/AIDS related medications for the client until that individual meets their TrOOP requirement.

President's Principles—Severity of Need Index

Background: The treatment of HIV is extremely complex. Noncompliance with medication regiments can reduce their effectiveness and can even result in the development of harmful drug resistance. It is crucial that required medications are provided but other support is also necessary to ensure compliance. Compliance also depends on treating co-morbid medical conditions, mental health and substance abuse conditions, and ensuring secure social situations.

Question 5. What is the current State of developing a severity of need index at HRSA and how do you plan to take into account such complicated and diverse factors as mental illness, drug abuse, hepatitis C co-infection, and housing costs?

Answer 5. Both the IOM Report "Measuring What Matters" and recent GAO reports have concluded that there are large differences across EMAs and States in allocations per estimated living AIDS case due in part to the double counting provision in current law. A "severity of need" formula that is based on more objective, quantitative, and nationally available data would distribute funding more equitably to address disease burden, costs of providing care, and available area resources. The HRSA has continued to study the IOM's recommendations and is exploring possible quantitative indicators of severity of need that could be used as means to improve the process for determining the amount of funds a grantee may receive. As part of this exploratory process, HRSA is consulting with national experts and its grantees to ensure a severity of need measure does not penalize generous States nor reward States that have failed to contribute resources to address the HIV/AIDS epidemic within their jurisdiction.

Question 6. We have concerns that title IV would be severely damaged if funds were set aside for "core medical services." First, title IV is successful because it offers a broad range of family-centered services that are essential to mothers struggling to take care of their own health and the health of their children, to giving mom the support she needs, like child care and transportation to doctor appointments and pharmacies, and to reaching out to HIV-infected youth. Second, 80 percent of title IV's consumers have Medicaid, so for most patients, doctor appointments and medications are paid for by another source. What isn't necessarily covered by other sources, and what is key to title IV, are the services that bring marginalized families struggling with HIV into care.

So, my question to you is what changes would the Administration like to see made to title IV? And, specifically, do you want Congress to apply a set-aside of title IV funds for "core medical services?"

Answer 6. Although the title IV program of the CARE Act is structured differently than the other titles, in essence the main goal is to assure that its clients receive core medical services, including primary medical care and medications. Because there is no final definition of core medical services as yet, it is difficult to predict which, if any, of the title IV funded services may face a possible reduction in funding. It is anticipated that many CARE Act programs may have to make modifications to their programs based on the application of the requirement to spend 75 per-

cent of their funds on "core medical services." However, the change is designed to assure quality health care for HIV-infected individuals and uniformity of services for CARE Act clients across the country.

QUESTIONS OF SENATOR CLINTON

Question 1. In a response to a letter I sent to you in October with my colleagues in the New York delegation outlining our concerns over the President's principles, you stated that the principles are "proposing to target Federal funds to the most heavily impacted communities and to serve the neediest first." Such a statement would seem to indicate strong Administration support for New York, the State that has borne the brunt of this epidemic, and, in 2004, had more new HIV infections than any other State.

Yet, if the Administration's principles were implemented, New York would experience decreases in funding that would devastate our ability to provide care and treatment to people living with HIV. Specifically, the principles would require 75 percent of funds to be spent on a yet-to-be-defined list of medical services, establish a severity of need index that would take into account State spending, and make changes in the title II formula that would shift funding away from areas with title I eligible metropolitan areas. Could you please detail exactly how the Administration's proposal for reauthorization would help, not hurt, heavily impacted communities with demonstrated need, like New York?

Answer 1. The President's principles call for more equitable distribution of CARE Act funds, which is paramount in the reauthorization. Changes in the CARE Act are not intended to destabilize services, but are designed to assure that persons in need of HIV services and unable to pay for them shall be able to receive those services, both in urban communities and in rural communities. By maintaining important provisions in the legislation, such as maintenance of effort and matching fund requirements, the Administration will ensure that States continue to contribute State and local funds to critical HIV/AIDS services to minimize any impact that redistribution of CARE Act funds might have.

Question 2. The Administration's principles call for developing a severity of need index that takes into account the resources that State and local governments have provided to address the epidemic. Such a principle acts as a disincentive to providing additional funding, and may result in State and local governments shifting resources away from AIDS programs so they will not be penalized by this new severity of need index. Has the Government taken into account the increased burden that might be placed upon the Ryan White program if this principle were to be put into effect?

Answer 2. The President's principles call for more equitable distribution of CARE Act funds. Important provisions in the current law, such as maintenance of effort, payer of last resort and matching fund requirements, will continue to safeguard against the diversion or reduction of State and local funds away from critical HIV/AIDS services. We will continue to be vigilant to ensure that new CARE Act dollars will not be used to supplant State and local efforts.

Question 3. Currently, the Ryan White CARE Act provides funding that helps people living with AIDS not only gain access to medication, but the support services that help them not only enter, but remain within our health care system, like nutrition services, case management and emergency housing assistance. The President's principles call for 75 percent of all CARE Act funding to be directed to an as-yet-undefined set of core medical services. What specific services does the Administration propose to designate core medical services? If the services listed above are excluded, what is the Administration's rationale for excluding them? In addition, during the hearing, you mentioned that the Administration has looked at several examples of core medical service lists in formulating its principles. It would be helpful to learn which lists were examined by the Administration in formulating their principles.

Answer 3. Various groups have developed lists of "core medical services" for people living with HIV and AIDS. In particular, the IOM study, "Public Financing and Delivery of HIV/AIDS Care," published in 2004, defined eight broad areas that capture the critical components of HIV care as listed below:

- Outpatient primary care medical services;
- Medications, including HAART;
- Other drug therapies for HIV-related comorbidities;
- Laboratory and radiological services;
- Oral health care;
- Obstetrics and reproductive health services for HIV-infected women;

- Outpatient mental health and substance abuse services;
- Home health and hospice care;
- Medical case management; and
- HIV prevention services.

Question 4. The development of a needs-based index is of concern insofar as data that would be used to make allocation decisions might not be universally available. For example, one important measure of need would be HIV cases, but we know that name-based HIV surveillance data is not collected in all States. Since data are not universally available for even the most basic measure of need for HIV services, can you explain how the Administration plans to develop a meaningful, scientifically sound, feasible needs-based funding formula?

Answer 4. The Administration's CARE Act reauthorization principles call for the establishment of objective indicators to determine severity of need (SON) for funding of core medical services and proposes that such an index take into account HIV prevalence, poverty rates, availability of resources including local, State and Federal programs and support, and private resources. There are established national data bases from sources including Census, Labor, CDC, CMS, and HRSA that are being examined by HRSA in response to the IOM report, "Measuring What Matters: Allocations, Planning, and Quality Assessment for the Ryan White CARE Act," that may be utilized in the development of a meaningful and scientifically sound needs-based funding formula. Insofar as the status of HIV surveillance data collection by all States, the CARE Act requires that all States have HIV reporting in place by 2007 to receive formula grants under titles I and II of the act. The fact that the SON index will need to take into account HIV data means that there will need to be close coordination in the implementation of both HIV data and the SON index proposals.

Question 5. The Administration has proposed a $70 million increase in funding for the Ryan White CARE Act for fiscal year 2007. How many of these dollars will go toward increasing funding in already existing programs other than the AIDS Drug Assistance Program (ADAP)?

Answer 5. The Administration has proposed an increase of $95 million in funding for the Ryan White CARE Act for fiscal year 2007. Of this amount, the $70 million increase in funding would help the States end current ADAP waiting lists and support care for additional patients. The entire $70 million has been requested in title II, which supports ADAP. The additional $25 million increase is to expand outreach by providing as many as 25 HIV community action grants to community and faith-based organizations to provide technical assistance and sub-awards to grassroots organizations. HRSA believes that the requested funds would not be subject to the current statutory provisions of the CARE Act including: Hold Harmless, Emerging Communities, Maintenance of Effort, State Matching, and Formula distribution.

Question 6. The Ryan White CARE Act is designed to be the payer of last resort. In many States, Medicaid and State funds help pay for medical services. Implementing a 75 percent rule would likely lead States to limit coverage of medical services through Medicaid and State funds and begin paying for them with Ryan White CARE Act funds. As a result, what had been the payer of last resort would become the payer of first resort. How has the Administration accounted for the increased burden that will be placed on the CARE Act through the implementation of this rule? Will implementation of this provision result in increased numbers of uninsured individuals, and if so, who will then assume the costs of care?

Answer 6. As the payor of last resort, the CARE Act was designed to build around the core of Medicaid services for people living with HIV/AIDS either by filling in the gaps in covered services for people who already had Medicaid or by providing services to individuals unable to afford them but were also ineligible for Medicaid. Medicaid is at the center of the care delivery system for people living with HIV/AIDS. CARE Act grantees recognize that services that are eligible under Medicaid and other third party payers must be billed first to those payers and that the CARE Act is the payer of last resort. By maintaining important provisions in the current law, such as maintenance of effort and matching fund requirements, the Administration will ensure that States continue to contribute State and local funds to critical HIV/AIDS services.

Question 7. Why did the Administration choose 75 percent as the minimum threshold States should meet in providing core medical services? Do any States or eligible metropolitan area (EMA) currently meet the 75 percent threshold? Is there research to suggest that imposing this type of requirement will result in better managed services?

Answer 7. Advancements in HIV/AIDS care and treatment mean that people living with HIV/AIDS are living longer and healthier lives. Efforts to identify persons earlier in disease progression and bring them into care also means an increasing number of uninsured or underinsured are dependent on the CARE Act for care and treatment. Under current law, the Ryan White CARE Act (RWCA) providers have a broad range of services they may offer their patients. Although all services have value, only some can be considered life-saving and life-extending. In addition, the services offered to RWCA beneficiaries vary across geographic regions. This proposed change is designed to foster health among HIV-infected individuals and uniformity of services across the country by designating a basic set of core health care services for RWCA beneficiaries. The components of core services have not been defined but would, at a minimum, include health care services and medications for which 71 percent of CARE Act funding was directed in 2004. Thus the 75 percent minimum is in line with program expectations and supported by program data. Both title I and title II program guidances describe the elements of a continuum of care and utilize the term "core services." In the 2005 title I guidance, grantees were asked to prioritize essential core services, describe the priority setting and allocations processes, and how data were used in this process to increase access to core services. Grantees were also asked to justify other sources of core services if funds are not allocated to these services. For the top services they identified, including core services, grantees were asked to develop one or more service goals for each priority with time-limited and measurable program objectives.

Question 8. The Administration has included as part of its principles for reauthorization a call to eliminate the 80–20 formula allocation in title II, claiming this allocation leads to funding discrepancies between States with title I EMAs and States without title I EMAs. However, when doing an analysis of funding from all four titles, this discrepancy in funding is no longer apparent. Why is the Administration focusing solely on title I and II, rather than examining total CARE Act funding received within States?

Answer 8. The Administration is focusing on legislative provisions in the CARE Act that affect the equitable distribution of funds. These apply entirely to the title I and title II programs. The remaining programs under the CARE Act are discretionary grant programs and awarded based principally on the lack of availability of other CARE Act resources in the State, locality, or community applying for such resources.

Question 9. There are several EMAs that serve people with AIDS from more than one State. For example, the Kansas City EMA serves patients in Missouri, a State with an EMA, and Kansas, a State without an EMA. How has the Administration factored in the negative impact that elimination of the 80–20 formula will have upon States without EMAs that rely upon an EMA to provide services to many of its residents?

Answer 9. Under the President's principles, the concept of double counting would be eliminated. With regards to the situation in Kansas, the State would receive the benefit of the proportion of estimated living AIDS cases within the State that are outside of the boundaries of the EMA. In Kansas, approximately 64 percent of the cases fall into this category. In the State of Missouri, only 24 percent of the State's AIDS cases reside outside of the EMA area. This same methodology would be true for other EMAs/States where the EMA crosses State lines.

Question 10. The President's principles call for the implementation of routine HIV testing in public facilities. How does the Administration propose to pay for routine testing in these facilities?

Answer 10. An important feature of recommendations for routine HIV screening in health care settings is that screening becomes eligible for third-party reimbursement, analogous to other recommended screening (e.g., Chlamydia screening, mammography, cholesterol screening). Detecting HIV infection earlier through HIV screening (and optimizing opportunities for effective treatment and prevention) has been shown to be cost-effective, even in settings of low HIV prevalence. CDC anticipates that payers will be encouraged to cover screening, either separately or as part of the basis for payment to hospitals. Because HIV screening is cost-effective, some facilities may also choose to absorb the cost, or to redirect funds from other, less cost-effective programs. Public funds will continue to be necessary to support screening programs for indigent persons who have no health care coverage.

Question 11. The Administration has endorsed opt-out testing. In this form of testing, a patient will be automatically tested unless he or she declines to be tested. How does counseling fit into this paradigm?

Answer 11. Opt-out HIV screening has been endorsed for health care settings. Under opt-out testing, the patient is notified that HIV screening for all patients is routine, and the patient has the opportunity to ask questions and to decline testing. The provision of counseling at the time of disclosure of results will not change from current practices for persons who test positive for HIV. However, prevention counseling (i.e., pre-test counseling with the development of a risk reduction plan, and post-test counseling for HIV-negative persons) is not recommended in conjunction with HIV screening programs in health care settings. Several studies have shown that both patients and providers often perceive such counseling to be a barrier. Because of time constraints and other considerations, when conventional counseling and testing are recommended for health care settings, most patients receive neither. CDC's position, supported by numerous professional and consumer organizations, is that HIV screening in health care settings should be treated as an intervention distinct from HIV counseling as a prevention intervention. HIV counseling should be part of routine health promotion counseling in health care settings. In episodic care settings (such as emergency departments and acute care settings where confidentiality is difficult to achieve) it is usually not practical, and often not appropriate, to engage in intimate discussions of sexual or drug using behaviors. Experience has shown that for patients who are familiar with HIV and its consequences, such counseling is not necessary; for patients with substantial behavioral risks for HIV, counseling is likely insufficient. Please note that CDC is not recommending an opt-out approach in non-health care settings. In these settings, CDC's recommendations to provide counseling at the time of testing remain unchanged.

Question 12. If HIV testing and counseling were to be incorporated into primary care services, how does the Administration propose to ensure that in a routine exam, the patient and doctor will be able to have a comprehensive conversation about HIV testing? Is the Administration proposing additional reimbursements for doctors as an incentive for providing testing as part of routine health care?

Answer 12. CDC's proposed revised recommendations suggest that all persons receive HIV screening; they do not recommend that doctors have a comprehensive conversation about HIV testing with all patients. CDC proposes that HIV testing be treated like any other screening or diagnostic test. CDC anticipates that providers will use their clinical judgment in determining how much health promotion or education about HIV is warranted for each patient. Ample data from the National Health Interview Survey indicate that, by the mid-1990s, the U.S. population exhibited high levels of knowledge about HIV, HIV testing, and risk factors for HIV transmission. Emerging data suggest that singling out HIV testing (by imposing specific requirements for counseling or pre-test information) is likely to perpetuate the stigma surrounding HIV testing. Qualitative research among high-risk consumers indicates that most already perceive HIV testing to be part of routine health maintenance, like mammograms or blood pressure checks. U.S. health care providers already conduct 14 million to 16 million HIV tests annually. Routine HIV screening has been shown to be cost effective, and CDC anticipates that routine HIV screening will be eligible for third-party reimbursement by those who already fund guideline-concordant care (such as private insurers, Medicare, and Medicaid.)

Question 13. Assuming the current allocations for funding, and based on the most recent reports sent in by grantees, how many people, in both whole numbers and percentage by titles and States, is the CARE Act serving?

Answer 13.

Number of Duplicated Clients Served by Ryan White CARE Act Programs*

Program	2002	2003	2004
Title I	778,457	840,421	736,813
Title II	605,414	650,014	652,159
Title III	300,369	302,741	322,417
Title IV	194,666	199,858	215,819
ADAP	136,345	143,711	142,653

*Clients may receive services from multiple providers that may, in turn, receive funding from one or more CARE Act programs. Thus, client counts by title are not mutually exclusive. In addition, while data are unduplicated at the provider level, any summary of the total number of clients served and their demographic characteristics at the grantee or national level may result in duplicated client counts.

Ryan White CARE Act, 2002–2004

Number of Duplicated Clients Served by State*

State/Territory	2002	2003	2004
Alaska	603	603	587
Alabama	7,675	12,045	11,884
Arkansas	1,616	1,637	1,893
Arizona	14,622	18,373	18,042
California	156,605	153,327	147,530
Colorado	8,705	7,886	10,678
Connecticut	14,968	14,010	16,028
Washington, DC	20,424	40,766	13,870
Delaware	3,696	3,584	3,741
Florida	144,920	144,005	120,708
Georgia	28,661	23,402	25,427
Hawaii	1,637	1,798	1,974
Iowa	1,361	1,846	1,556
Idaho	401	602	490
Illinois	25,885	29,528	33,033
Indiana	3,542	1,947	4,399
Kansas	2,378	2,804	3,542
Kentucky	3,446	3,890	3,825
Louisiana	21,919	22,853	22,328
Massachusetts	24,433	22,291	22,805
Maryland	25,915	31,670	27,424
Maine	840	1,154	1,042
Michigan	14,581	12,786	12,319
Minnesota	5,983	6,481	6,964
Missouri	14,057	15,321	15,009
Mississippi	3,835	4,421	4,312
Montana	368	519	361
North Carolina	12,425	13,585	13,917
North Dakota	60	65	56
Nebraska	1,700	1,454	1,673
New Hampshire	1,864	1,258	1,426
New Jersey	53,437	52,968	46,744
New Mexico	1,406	1,581	1,592
Nevada	6,665	6,363	7,521
New York	153,586	177,912	156,492
Ohio	17,270	15,244	15,521
Oklahoma	2,845	2,873	2,789
Oregon	6,276	5,294	5,916
Pennsylvania	53,019	47,113	64,483
Puerto Rico	18,370	18,521	23,363
Rhode Island	3,304	2,975	3,468
South Carolina	9,336	10,255	13,824
South Dakota	74	205	214
Tennessee	12,969	14,868	19,169
Texas	102,954	134,857	100,118
Utah	1,598	2,927	2,918
Virginia	11,128	11,253	10,098
Virgin Islands	324	443	231
Vermont	655	672	611
Washington	11,211	11,425	12,357
Wisconsin	7,739	6,343	6,359
West Viriginia	872	828	1,032
Wyoming	**	125	64

*Clients may received services from multiple providers with a State.Thus, client counts by title are not mutually exclusive. In addition, while dataare unduplicated at the provider level, any summary of the total number of clients served and their demographic characteristics at the grantee or national level may result in duplicated client counts.

**No data reported

Question 13a. Since the President's principles call for holding grantees accountable for client-level data counts, how are the numbers of clients currently compiled, and what is the level of accuracy in these estimates?

Answer 13a. Every year, recipients of CARE Act funds (grantees and their service providers) are required to report to the Health Resources and Services Administration's HIV/AIDS Bureau (HRSA/HAB) how those funds have been used to provide

services to low-income and underserved individuals and families living with HIV/AIDS. The Ryan White CARE Act Data Report (CADR) is the annual reporting instrument that must be completed by agencies and organizations receiving funds to describe: (1) characteristics of their organization; (2) the number and characteristics of clients they served; (3) the types of services provided; and 4) the number of clients receiving these services and the number of client visits by type of service. Agencies/organizations that provide counseling and testing services report on the number of individuals receiving these services. In addition, providers of ambulatory/outpatient medical care provide some information on the outcomes of their services.

The utility of CADR data is limited by **duplicated client counts**. CADR data as collected and reported by individual service providers are generally unduplicated. However, since an individual client may receive services from more than one provider, there is no way of knowing that the counts of individuals served by one provider are not also included in the counts of another service provider. Thus, aggregating the provider data to the grantee, State and/or national level results in duplicate client counts. The estimated rate of duplication for CARE Act data at the national level is 45 percent to 55 percent.

Question 13b. Given that the IOM has stated that code-based systems can be used accurately and effectively, how is HRSA working with code-based States to increase the accuracy of the system?

Answer 13b. CDC appreciates the opportunity to clarify our understanding of the IOM's findings presented in the report entitled "Measuring What Matters" and to describe our technical assistance activities with States that are implementing HIV reporting systems using patient identifiers other than the name of the person diagnosed with an HIV infection. CDC, rather than HRSA, has the charge to develop a nationwide HIV/AIDS surveillance system.

The IOM did not evaluate the accuracy or effectiveness of code-based systems. The IOM noted in the report that it was beyond its capacity to evaluate the HIV case-reporting system of each State and territory. Additionally, the IOM did not evaluate the use of HIV reporting data for public health purposes, such as epidemic surveillance. The IOM focused on the issue of "whether incorporating HIV reporting into the RWCA formulas would provide a better representation of HIV disease-related resource needs across jurisdictions and more fairly channel scarce RWCA resources." The IOM concluded that the reporting of HIV cases was not complete and accurate enough nationwide to allow these HIV case numbers to be used in determining how funds from the Ryan White CARE Act should be allocated among States and metropolitan areas.

Despite these recognized limitations, the IOM provided three recommendations for improving national HIV reporting for the purpose of resource allocation:

(a) "The CDC should accept reported HIV cases from all States. Until this occurs, large numbers of HIV cases will not be included in the national HIV reporting system, and there will be no reliable centralized way to use reported HIV cases to apportion CARE Act funds. CDC should work with all States to develop and evaluate methods for unduplicating HIV cases regardless of whether such cases are code- or name-based. The Secretary of HHS should provide CDC with the funding to provide the technical assistance to States necessary to support the integration of code- with name-based data into the national HIV reporting database. Because of the importance of obtaining consistent data from all jurisdictions, the CDC should include HIV reporting data from code-based States and estimate the degree of overcounting due to duplication while procedures and infrastructure for definitive unduplication are developed.

(b) CDC should collaborate with all States to periodically assess and compare the completeness and timeliness of their HIV reporting systems.

(c) The Secretary of HHS should provide additional funds to CDC to assist States in improving the completeness and timeliness and overall comparability of their HIV reporting systems. Enhancing electronic laboratory reporting in all States is critical in achieving this goal. Pharmacy-based surveillance, with a focus on the ADAP, is another potential source of information for enhancing completeness."

The IOM did not recommend that CDC accept code-based data because "code-based systems can be used accurately and effectively," but rather the IOM determined that there was insufficient evidence to conclude that no potential method could be developed to integrate data from both of these systems for the purpose of de-duplicating cases across States. The committee also noted that code-based reporting systems were developed by some States after substantial political debate, and altering those systems would require significant legislative changes, time, and effort.

The IOM did not have available the final results of the Interstate Duplication Evaluation Project when it made these recommendations. The Interstate Duplication Evaluation project made clear that technical problems made it impossible to efficiently include code-based reports. These problems included: (1) the variety of codes used by the different States conducting this type of surveillance; (2) the lack of a central, standardized, national database with code-based reports; and (3) the inability of States using codes to adequately communicate with States using names regarding potential duplicate records. Therefore, only name-based reports could be included. The results of this assessment indicated that the number of duplicate reports for non-AIDS HIV cases varied a great deal from State to State, and exceeded the proportion of duplicate case reports for AIDS cases. CDC's policy is to accept only HIV infection and AIDS case surveillance data from the areas conducting confidential name-based reporting because name-based reporting has been evaluated and has historically achieved high levels of accuracy and reliability.

CDC is providing technical assistance to States transitioning from code- to name-based systems to assure that their data can be integrated into the national HIV (non-AIDS and AIDS) data system as quickly as possible. CDC has assisted the seven States that have made the transition to name-based systems since the IOM report was published in 2004. Currently 43 States have adopted use of name-based systems of HIV reporting.

CDC continues to provide funding and technical assistance to States that use code-based methods for identifying patients in their HIV surveillance system. CDC is implementing and disseminating methods for conducting evaluations of the accuracy and reliability of reporting systems within States, regardless of reporting method. CDC is deploying data management software that integrates functions that will allow areas to use standardized methods to evaluate their systems based on recently completed pilot studies. In addition, CDC regularly offers technical assistance to areas using code-based systems that have not received this software. This assistance includes the software, and relevant documentation, that was used in the pilots.

Question 14. How is HRSA working with the CDC to help high-incidence States prevent new infections and reduce incidence rates? What specific programs does HRSA have to help high-incidence States serve the needs of newly detected individuals?

Answer 14. The CDC Advancing HIV Prevention Initiative aims to reduce HIV transmission by encouraging people to learn their HIV status; provide referrals to care, treatment, and prevention services; and to prioritize prevention services for persons with HIV. All of the CDC initiative's main precepts directly affect HIV care and the Health Resources and Services Administration (HRSA) HIV/AIDS Bureau's (HAB) programs: to make HIV testing a routine part of medical care; to prevent new infections by working with persons diagnosed with HIV and their partners; and to further decrease perinatal transmission by screening all pregnant women for HIV. HAB is working closely with the CDC to collaborate on projects that support the initiative, as well as working to promote HIV prevention, counseling, and testing in our HRSA programs. Activities that support the CDC's initiative currently include: training providers on HIV counseling and testing, use of the Rapid test and integrating HIV prevention into clinical care through our AIDS Education and Training Centers (AETC) programs; testing models that integrate prevention activities into clinical care settings; collaboration with CDC and other agencies to identify methods to streamline and integrate case management services; and ways to promote perinatal counseling and testing activities. In addition, CDC and HAB worked together in an effort to quantify the impact of this initiative on HIV care and treatment programs.

Question 15. In the past 3 fiscal years, what percentage of funding by title has gone to the administrative tap? In addition to the SPNS program, how has this evaluation tap been used on a title-by-title basis?

Answer 15. All Ryan White Titles are reduced less than 1 percent for administrative costs. These costs include program costs budgeted centrally. An example of this is the review of grant applications which are conducted by the Division of Independent Review in the Office of the Administrator. This office procures contract services to assure that HRSA's grants and contracts have an independent review that assures that the process if fair, open, and competitive.

As specified in an Agency's appropriations language, PHS Evaluation funds support critical evaluation activities throughout HHS. These evaluations, and the data collection and analysis that support them, improve program performance by ensuring that timely and accurate information is available to support funding and management decisions. PHS Evaluation funds are used to promote health care quality

improvements through research using scientific evidence regarding all aspects of health care including the Ryan White Special Projects of Nation Significance (SPNS). In Ryan White, PHS Evaluation funds are used solely for the SPNS program.

Question 16. Could you please explain how HRSA is working with community health centers (CHC) to provide care to individuals with HIV? How much funding from the CARE Act is being directed to CHC-provided services, and how many HIV+ individuals are being served by these CHCs?

Answer 16. The HIV/AIDS Bureau works closely with the Bureau of Primary Health Care to provide outpatient primary care and support services for people living with HIV who receive care in Ryan White CARE Act funded programs and in community health centers. Community health centers receive funding from each Title of the Ryan White CARE Act.

	# of CHCs Funded by RWCA*	Amount of CARE Funding to CHCs in FY 2004	# of HIV+ Clients Served in these CHCs**
Title I	73	$25,751,980	33,198
Title II	71	$14,281,670	28,602
Title III	130	$59,232,352	48,708
Title IV	7	$ 3,301,092	11,518

*Community health centers may receive funding from multiple CARE Act programs. Counts of CHCs by title are not mutually exclusive.

**Clients may have received services from multiple providers that may, in turn, receive funding from one or more CARE Act programs. Thus, client counts by title are not mutually exclusive. In addition, while data are unduplicated at the provider level, any summary of the total number of clients served and their demographic characteristics at the grantee or national level may result in duplicated client counts.

Additionally, title IV programs identify HIV-positive pregnant women and connect them with care that can improve their health and prevent perinatal transmission.

Title III and IV program services are integrated into CHCs and include:

- Risk-reduction counseling on prevention, antibody testing, medical evaluation, and clinical care; including prenatal and dental care.
- Antiretroviral therapies; protection against opportunistic infections; and ongoing medical, oral health, nutritional, psychosocial, and other care services for HIV-infected clients;
- Case management to ensure access to services and continuity of care for HIV-infected clients;
- Mental Health Services; and
- Attention to other health problems that commonly occur with HIV infection, including tuberculosis and substance abuse.

Question 17. How many health care professionals are trained by the AETCs per year? What recommendations would HRSA make to ensure that AETCs are able to train all health professionals who seek to serve individuals with HIV?

Answer 17. During the grant year 2003–04, the AETCs conducted a total of 14,211 training events. These events amounted to 47,585 hours of instruction. A total of 6,704 group trainings took place, representing Level I–IV training events. An estimated 73,239 individuals attended these group trainings. In addition, 5,166 individual clinical consultation events as well as 2,341 technical assistance (TA) training events took place.

Trainers reported that 142,393 participants attended Level I–IV training events. (This number is a duplicated count of providers trained because the same individual could attend multiple trainings throughout the year.) Level V training events did not report number of participants.

The program targets providers who treat minority, underserved, and vulnerable populations in communities most affected by the HIV epidemic.

Question 18. Could you please outline the ways in which you work with the CDC to develop HIV and AIDS case counts in each State? What are your current state-by-state estimates of incidence and prevalence for HIV and AIDS?

Answer 18. CDC provides HRSA the following types of data:

(1) Every year CDC provides AIDS case counts for States and EMAs, based on reports to local and State health departments by name for the previous 10 12-month periods. These data are not adjusted in any way and constitute crude counts of reported cases. This is prescribed in the current Ryan White Care Act legislation.

(2) CDC also provides reported cumulative AIDS case counts to identify areas that qualify as EMAs and Emerging Communities.

(3) Until recently, CDC has provided HRSA with incidence and prevalence data on AIDS diagnoses, as well as prevalence data on HIV diagnoses for 33 States, adjusted for reporting delays and risk redistribution based on case report data submitted by the States. The last set of these data provided to HRSA included estimates for cases diagnosed through 2004. Data on HIV (not AIDS) were only included from States with confidential, name-based HIV reporting. AIDS data from all States were included in these data tables because all States use confidential, name-based reporting for AIDS surveillance. These data were not used directly within a formula to determine funding, but are provided to the States to include in their applications in order to depict the epidemiologic picture of the HIV/AIDS burden in their area. However, this assistance is no longer needed. As part of the CDC program called "Epidemiologic Capacity Building" CDC has been providing the States with software to conduct the necessary analyses using their own data to generate these estimates. The States will be able to generate their own numbers for completing their applications. Therefore, CDC informed HRSA in 2005 that it would no longer provide these estimates to HRSA.

The latest published estimates of HIV and AIDS were published in the CDC HIV Surveillance Report, Volume 16 (http://www.cdc.gov/hiv/topics/surveillance/resources/reports/2004report/pdf/2004SurveillanceReport.pdf).

AIDS prevalence data are available from all States, and HIV (not AIDS) prevalence data were published from 33 States with long-standing, HIV reporting. AIDS incidence data are provided in Table 3; HIV incidence data are not available. Unlike data provided to HRSA for use in funding allocations, the data published in this report were adjusted for reporting delays. CDC recommends that unadjusted data be used for funding allocations.

[Whereupon, at 4:20 p.m., the committee was adjourned.]

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